STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(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 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		3/29/18

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

Electronically Signed | 03/21/2018

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F 580	Continued From page 1 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and staff and physician interview, the facility failed to notify the physician of the resident ' s refusal of the blood draw resulting in continued medication administration of potassium chloride without a blood potassium level as ordered reviewed for unnecessary medication for 1 of 2 residents (Resident #48). Findings include: Resident #48 was admitted to the facility on 1/15/18. Resident #48 ' s admission Minimum Data Set dated 1/23/18 revealed the resident had adequate hearing, was rarely understood and usually understands. The resident's cognition was not able to be evaluated due to the inability to communicate. The resident had no behaviors. The resident required extensive assistance of two staff for transfers, one staff for personal care and dressing, and set up for meals. The resident's cumulative diagnoses were hypertension, retention of urine, and total brain injury. Resident #48 ' s care plan dated 1/15/18 revealed there were goals and interventions for	F 580	Disclaimer Notice: Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of alleged deficiencies but is prepared for the sole purpose of compliance with State and Federal Regulations. F580 1. Resident #48□s condition remains stable. His primary physician has discontinued the use of his potassium chloride supplement on 3-1-18 and therapeutic laboratory draw. 2. A facility wide audit was completed by the Unit Manager on 3-20-18 of all current residents who have received medication orders for which corresponding therapeutic laboratory monitoring through phlebotomy draws were ordered in the past thirty (30) days has been conducted to evaluate compliance with the physician□s order and/or physician/prescriber notification of either the abnormal lab results or the inability of the facility to carry out the orders as written. The audit reveals that seven (7)	

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F 580	Continued From page 2	F 580		

hypertension, cognitive and communication deficit, seizure/total brain injury, and at risk for nutrition deficit.

A physician order dated 1/26/18 revealed Potassium Chloride 20 milliequivalents (MEq) each day and to check the potassium level in 2 weeks on 2/9/18.

A review of Resident #48 ' s January 2018 and February 2018 medication administration record revealed that the resident received KCL 20 MEq from January 1/26/18 through March 1, 2018.

A review of Resident #48 ' s facility record did not reveal a laboratory result for blood level potassium for February 2018.

The 24-hour report dated 2/9/18 revealed the resident had refused his blood draw that day.

A review of the nurses ' notes for 2/9/18 did not reveal the physician was informed of the resident ' s refusal of the blood draw.

On 2/18/18 at 2:00 pm an interview was conducted with the Director of Nursing (DON). The DON stated the she expected staff to make another attempt to draw the resident ' s blood when there was a refusal and if unable to notify the physician. The DON stated the resident continued to receive the potassium chloride without a blood potassium level. The DON stated that she expected staff to call the physician when they are unable to carry out an order.

On 2/28/18 on 2:10 pm an interview was conducted with the physician. The physician stated on 1/26/18 he ordered Resident #48 therapeutic labs ordered in conjunction with medications which are pending laboratory draws or results. Physicians are aware of impending laboratory draws and/or reports.

3. The facility has reviewed its policy on physician notification practices. No revisions are necessary to this policy currently. 24-hour chart check process and laboratory log management process reviewed. No revisions are necessary, and reinforcement of the process has been strengthened. All licensed nurses which include full time (FT), part time (PT), and per diem (PD) will be re in-serviced by the Staff Development Nurse or Director of Nursing on the following: 1) physician notification policy which addresses the need to notify the physician/prescriber should his/her orders be unsuccessfully implemented and why, 2) 24-hour report where pending labs shall be documented until obtained and 3) laboratory log management for daily review and management of scheduled and completed laboratory draws are entered by 3-29-18.- Staff will not be scheduled or assigned to work until they attend the inservice after 3-29-18.

4. The Quality Assessment and Assurance (QAA) Coordinator and its members as noted below (Director of Nursing, Unit Manager, Charge Nurse, and Quality Assurance Nurse)will be responsible for the ongoing monitoring of this process through the 1) Daily 24-hour chart checks conducted by night shift

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F 580	Continued From page 3 potassium chloride 20 MEq each day and to have a repeat potassium level blood drawn on 2/9/18 to manage the resident's low blood potassium lab level. The physician stated staff should have called when the resident refused his blood draw because the blood potassium level was required to continue administration of potassium chloride. The physician instructed staff to medicate the resident for pain and try and obtain the blood draw again. The physician stated continuing to administer the potassium chloride without a blood potassium level would be considered minor harm. On 3/1/18 at 8:20 am an interview was conducted with Nurse #3. Nurse #3 stated that the physician requested Resident #48 have a blood draw for potassium level this morning. The resident refused the blood draw again this morning. Nurse #3 stated she would speak with the physician regarding the refusal and whether he would discontinue the potassium chloride. On 3/1/18 8:29 am Nurse #3 stated that the physician discontinued Resident #48 ' s potassium chloride.	F 580	nurses; ensuring that physician□s orders are processed for implementation, 2)Daily, the Director of Nursing (“DON”), Unit Manager and/or charge nurse will review of the 24-hour reports noting all new orders for meds and corresponding laboratory monitoring; validating the accurate processing of the same. 3) In addition, a monthly a laboratory audit will be performed for three (3) months by the Quality Assurance Coordinator and/or Unit Manager; confirming compliance with all therapeutic laboratory tests ordered in response to prescribed medications. All findings will be promptly addressed, and responsive action reported to the QAA team during routine meetings. After three (3) months, the QAA team will determine the frequency of ongoing audits however the audits will occur not less than quarterly for one (1) year. Date of Compliance: 3-29-18	
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	F 584		3/29/18

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F 584	Continued From page 4 possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §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 record review, observation and staff interview, the facility failed to clean the Packaged Terminal Air Conditioner (PTAC) filters and vents on 3 (rooms 101, 102, 103, 105, 111, 204, 210, 211, 212, 302 and 303) of 3 halls observed. Findings included: On 2/26/18 at 4:05 PM and on 2/27/18 at 8:49	F 584	F584 1. The Packaged Terminal Air Conditioner (PTAC) unit filters and vents in Rm. 101, 102, 103, 105, 111, 204, 210, 211, 212, 302 and 303 were cleaned on March 16, 2018. 2. A facility wide audit was completed by	

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F 584	Continued From page 5 AM, the PTAC units in rooms 101, 102 and 302 were observed. The filters were observed to be dusty and the vents had brown colored dust and with debris. On 3/1/18 at 9:30 AM, rooms 101, 102, 103, 105, 111, 204, 210, 211, 212, 302 and 303 were observed. The PTAC filters were dusty and the vents had brown colored dust and debris. On 3/1/18 at 9:50 AM, rooms 101, 102, 103, 105, 111, 204, 210, 211, 212, 302 and 303 were observed with the Maintenance Director. The Maintenance Director stated that he was responsible for cleaning the filters and the housekeepers were responsible for cleaning the vents. He observed the filters and the vents and verified that they needed to be cleaned. He stated that he changed the filters monthly but he would probably had to change it more often. On 3/1/18 at 9:55 AM, the Housekeeping supervisor was interviewed. She stated that the housekeepers only wiped the outside of the vents because the case has to be removed in order to clean the inside. She stated that she had no system in place for cleaning the inside of the vents. The Housekeeping supervisor observed the PTAC vents and verified that they needed to be cleaned. On 3/1/18 at 10:15 AM, the Housekeeping supervisor stated that she developed a cleaning schedule for the PTAC vents. She stated that from now on every time the room was scheduled for deep cleaning, the case of the PTAC unit will be removed by the Maintenance and the housekeeper will clean the vents.	F 584	the Director of Maintenance and Maintenance Assistant on 3-16-18 of all PTAC units in resident rooms conducted ensuring 1) functionality, and 2) filters to be free of dust and vents to be free of dust and discoloration. The findings of this audit note that 1) all PTAC units were functional, 2) all PTAC units were free of dust and 3) all PTAC units were free of discoloration. Furthermore, a follow up observation by the Licensed Nursing Home Administrator ("LNHA") on March 20, 2018 was conducted confirming all PTAC units to be as assessed without variance. 3. A review of the facility's environmental maintenance process which includes PTAC maintenance (inclusive of filters) was conducted. A new PTAC "checklist" has been developed by the Maintenance Assistant and introduced for use with PTAC checks. Maintenance Director accepts the PTAC checklist and understands its use. PTAC checks will be added to the pre-admission and post discharge room "checks" process. The PTAC unit checks have and will continue to be performed monthly with up to 30% of the PTAC unit checks performed by the Maintenance Assistant being spot checked by the Maintenance Director and/or LNHA. Housekeeping staff will continue to use a separate checklist for pre-admission and post admission room checks. Housekeeping will be re inserviced by the Housekeeping supervisor to the pre-admission and post	

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F 584	Continued From page 6 On 3/1/18 at 12:50 PM, the Administrator was interviewed. She stated that the housekeeping department was contracted from an outside company and she expected them to clean the PTAC units.	F 584	discharge room by 3-28-18. Staff will not be scheduled or assigned to work until they attend the inservice after 3-29-18. 4. The Quality Assessment and Assurance ("QAA") Coordinator and its members as noted below (Maintenance Director, Maintenance Assistant, LNHA, Housekeeping Supervisor, Quality Assurance Coordinator) will be responsible for the ongoing monitoring of this process through the 1) Room rounds prior to resident admissions and following a resident's discharge by the housekeeping supervisor and maintenance assistant confirming the presence of a clean PTAC unit. Checklists will be maintained with details of shared with the QAA team during routine meetings. 2) Monthly PTAC checks will continue to occur; ensuring PTAC units are free of dust and discoloration. All findings will be promptly addressed by the Maintenance Director with validation by either the LNHA or the Quality Assurance Coordinator and reported during routine QAA team meetings. The Maintenance Director will report his findings and responsive action to the QAA team during routine QAA meetings for a minimum of monthly for three (3) months and then quarterly thereafter. The QAA team will determine changes to the audits (e.g. details, enhanced frequency, etc.) but should occur not less than quarterly for one (1) year. Date of Compliance: 3-29-18	
F 641	Accuracy of Assessments	F 641		3/29/18

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F 641 SS=E	Continued From page 7 CFR(s): 483.20(g)	F 641		

§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 interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of falls (Residents #14, #53, and #60), active diagnosis (Resident #40), medications (Resident #32), hospice and prognosis (Resident #278) for 6 of 22 sampled residents. The findings included:

1. Resident #14 was admitted to the facility on 3/26/15 and most recently readmitted on 9/22/16 with multiple diagnoses that included dementia with behavioral disturbance and a history of falls.

An incident report dated 10/26/17 indicated Resident #14 had a fall that resulted in 2 small red areas to his right back.

The quarterly Minimum Data Set (MDS) assessment dated 11/23/17 indicated Resident #14 had severe cognitive impairment. Section J, the Health Conditions Section, indicated Resident #14 had no falls since his previous MDS assessment (8/28/17).

An interview was conducted with the MDS Coordinator on 3/1/18 at 12:00 PM. Section J of the MDS dated 11/23/17 for Resident #14 that indicated he had no falls since his previous MDS assessment (8/28/17) was reviewed with the MDS Coordinator. The incident report dated 10/26/17 for Resident #14 that indicated he had 1

F641
1. The following Minimum Data Set ("MDS") modifications occurred as follows:
a. A significant correction to Resident #14's MDS with Assessment Reference Date ("ARD) of 11-27-17, Section J regarding the 10-26-17 fall was completed on 3-16-18.
b. A significant correction to Resident #53's MDS with an ARD of 1-20-18, Section J regarding the fall on 12-12-17 was completed on 3-16-18.
c. A significant correction to Resident #60 MDS with an ARD of 1-19-18 Section J to reflect the fall noted on 12-25-17 was completed on 3-16-18.
d. A significant correction to Resident #40's MDS with an ARD of 1-6-18 Section I was amended to regarding the 1-19-17 "other fracture" (wrist fracture) was completed on 3-2-18.
e. A significant correction to Resident #32's MDS with an ARD of 12-18-17, Section N regarding the usage of an antidepressant was completed on 3-16-18.
f. Resident #278 no longer resides in the facility.

2. A facility wide audit was completed by the MDS Nurse on 3-20-18 for all current

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F 641	Continued From page 8 fall with minor injury was reviewed with the MDS Coordinator. The MDS Coordinator revealed she had coded the 11/23/17 MDS incorrectly for Resident #14. She indicated she should have coded the 11/23/17 MDS for Resident #14 as 1 fall with minor injury. An interview was conducted with the Director of Nursing on 2/1/18 at 12:30 PM. She indicated she expected the MDS to be coded accurately. 2a. Resident #60 was admitted to the facility on 10/25/17 with multiple diagnoses that included dementia without behavioral disturbance. An incident report dated 12/25/17 indicated Resident #60 had a fall that resulted in a right knee abrasion. The 90-day Minimum Data Set (MDS) assessment dated 1/19/18 indicated Resident #60 had severe cognitive impairment. Section J, the Health Conditions Section, indicated Resident #60 had two or more falls without injury since his previous MDS assessment (12/20/17). An interview was conducted with the MDS Coordinator on 3/1/18 at 12:00 PM. Section J of the MDS dated 1/19/18 for Resident #60 that indicated he had two or more falls without injury since his previous MDS assessment (12/20/17) was reviewed with the MDS Coordinator. The incident report dated 12/25/17 for Resident #60 that indicated he had 1 fall with minor injury was reviewed with the MDS Coordinator. The MDS Coordinator revealed she had coded the 1/19/18 MDS incorrectly for Resident #60. She indicated she should have coded the 1/19/18 MDS for Resident #60 as 1 fall with minor injury.	F 641	residents and his/her most recent MDS assessment to evaluate the accurate coding of the following MDS sections: a. Coding on Section J (1700 to 1900)-related to falls; b. Coding on Section I (I0100-I800) related to active diagnosis; c. Coding on Section N (N0410 A-H) related to psychotropic medication; d. Coding on Section J (J1400) accurately reflects life expectancy of = 6 mo. AND e. Section O0100K accurately records the residents' Hospice Status The audit findings revealed that all current residents have timely MDS assessments completion and submission. Fourteen (14) MDS' modifications specific to sections J, I, N, or O were completed, submitted, and accepted by 3-21-18. 3. A review of the facility's MDS policy has been reviewed. No revisions are needed. The facility has the most current RAI manual at its disposal. A new MDS audit tool is being activated as a component of the QAPI process and ongoing MDS accuracy monitoring. The new MDS tool was reviewed with the Director of Nursing and unit manager (members of the QAA team) who will use the tool, by the regional nurse by 3-29-18. MDS Nurse is responsible completing sections J, I, N, and O and has been re-educated by the Director of Nursing on 3-24-18 on the appropriate coding for these sections; confirming understanding. Staff will not be scheduled or assigned to work until they attend the inservice after 3-	

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F 641	Continued From page 9 An interview was conducted with the Director of Nursing on 2/1/18 at 12:30 PM. She indicated she expected the MDS to be coded accurately. 2b. Resident #60 was admitted to the facility on 10/25/17 with multiple diagnoses that included dementia without behavioral disturbance. A review of Resident #60's medical record as well as a review of incident reports indicated he had no falls during the time period of 1/20/18 through 2/1/18. The quarterly Minimum Data Set (MDS) assessment dated 2/1/18 indicated Resident #60 had severe cognitive impairment. Section J, the Health Conditions Section, indicated Resident #60 had one fall without injury since his previous MDS assessment (1/19/18). An interview was conducted with the MDS Coordinator on 3/1/18 at 12:00 PM. Section J of the MDS dated 2/1/18 for Resident #60 that indicated he had one fall without injury since his previous MDS assessment (1/19/18) was reviewed with the MDS Coordinator. The medical record and incident reports that indicated Resident #60 had no falls during the time period of 1/20/18 through 2/1/18 was reviewed with the MDS Coordinator. The MDS Coordinator revealed she had coded the 2/1/18 MDS incorrectly for Resident #60. She indicated she should have coded the 2/1/18 MDS for Resident #60 as no falls since his previous MDS assessment (1/19/18). An interview was conducted with the Director of Nursing on 2/1/18 at 12:30 PM. She indicated	F 641	29-18. 4. The Quality Assessment and Assurance (“QAA”) Coordinator and the QAA team members as noted below (MDS nurse, DON and Unit Manager) will be responsible for the ongoing monitoring of this process through the 1) Weekly, the MDS nurse will review incident reports, noting all falls and fractures prior to completing section J (1700 to 1900) and submitting MDS’. 2) Weekly, the MDS nurse will review physician orders, Medication Administration Records (“MAR’s”) and Treatment Administration Records (“TAR’s”) prior to completing and submitting the MDS to ensure accurate recording of antidepressant medications in section N (I0100-I800), 3) Weekly, the MDS nurse will review diagnosis sheets and physician progress notes prior to completing and submitting section I (I0100-I800) and O (O0100K) of the MDS; confirming accurate recording of diagnosis that reflects a life expectancy of less than six (6) months as well as the election of hospice on the MDS and 4) Weekly for four (4) weeks the DON, or unit manager will review up to 30% of sections I (I0100-I800) , J (1700 to 1900), N (I0100-I800), & O (0100K) of prepared MDS’ using an MDS audit tool ensuring accuracy. Should this audit validate accurate codings, this audit will convert to bi-weekly for three (3) months. All findings will be promptly addressed with corrections or modifications made with	

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(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 641	Continued From page 10 she expected the MDS to be coded accurately. 3. Resident #40 was admitted to facility on 6/28/16 with multiple diagnoses that included dementia without behavioral disturbance and a history of falls. An incident report dated 11/9/17 indicated Resident #40 had a fall that resulted in a wrist fracture. A physician's order dated 11/11/17 for Resident #40 indicated Physical Therapy (PT) for 12 weeks for a wrist fracture. The quarterly Minimum Data Set (MDS) assessment dated 1/6/18 indicated Resident #40's cognition was moderately impaired. She was indicated to have had 1 fall with major injury since her previous MDS assessment. Resident #40 received PT services from 11/11/17 through 1/3/18. Section I, the Active Diagnoses Section, had not indicated "other fracture" related to Resident #40's wrist fracture. An interview was conducted with the MDS Coordinator on 3/1/18 at 12:00 PM. Section I of the MDS dated 1/6/18 for Resident #40 that had not indicated she had an "other fracture" was reviewed with the MDS Coordinator. The incident report that indicated Resident #40 had a fall resulting in a wrist fracture on 11/9/17 was reviewed with the MDS Coordinator. The physician's order dated 11/11/17 that indicated a referral to PT services for Resident #40's wrist fracture was reviewed with the MDS Coordinator. The MDS Coordinator revealed she had coded the 1/6/18 MDS incorrectly for Resident #40. She indicated she should have included the active	F 641	findings and responsive action reported to the QAA team during routine meetings. After three (3) months, the QAA team will determine the frequency of ongoing audits however the audits will occur not less than quarterly for one (1) year. Date of Compliance: 3-29-18	

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F 641	Continued From page 11	F 641		

diagnosis of "other fracture" on the 1/6/18 MDS for Resident #40

An interview was conducted with the Director of Nursing on 2/1/18 at 12:30 PM. She indicated she expected the MDS to be coded accurately.

4. Resident #32 was admitted to the facility on 9/6/17 with diagnoses that included dementia without behavioral disturbance.

A review of the December 2017 physician's orders included Remeron (antidepressant medication) 7.5 milligrams (mg) once daily for Resident #32.

The quarterly Minimum Data Set (MDS) assessment dated 12/18/17 indicated Resident #32's cognition was severely impaired. Section N, the Medications Section, indicated Resident #32 had not received antidepressant medication during the 7-day MDS review period (12/12/17 through 12/18/17).

A review of the December 2017 Medication Administration Record (MAR) for Resident #32 indicated she received Remeron on 7 of 7 days during the 12/18/17 MDS review period (12/12/17 through 12/18/17).

An interview was conducted with the MDS Coordinator on 3/1/18 at 12:00 PM. Section N of the MDS dated 12/18/17 for Resident #32 that indicated she had not received antidepressant medication during the 7-day MDS review period was reviewed with the MDS Coordinator. The December 2017 MAR that indicated Resident #32 had received Remeron on 7 of 7 days during the 12/18/17 MDS review period (12/12/17 through

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12/18/17) was reviewed with the MDS Coordinator. The MDS Coordinator revealed she had coded the 12/18/17 MDS incorrectly for Resident #32. She indicated she should have coded antidepressants on 7 of 7 days on the 12/18/17 MDS for Resident #32.

An interview was conducted with the Director of Nursing on 2/1/18 at 12:30 PM. She indicated she expected the MDS to be coded accurately.
5. Resident #278 was admitted to the facility on 5/2/12. Cumulative diagnoses included Alzheimer ' s disease.

A review of physician orders revealed an order dated 10/25/17 that stated admit to community hospice.

A Significant Change Minimum Data Set (MDS) Assessment dated 11/7/17 indicated Resident #278 had short and long-term memory impairment and was moderately impaired in daily decision making. A review of the Health Conditions section (J1400) revealed Resident #278 was not coded as having a prognosis of having had a condition or chronic disease that may have resulted in a life expectancy of less than 6 months. A review of Section "O" titled special treatments, procedures, programs revealed Resident #278 did not receive hospice services during the assessment period.

A Care Area Assessment for activities of daily living dated 11/7/17 stated, in part, Resident #278 had been a resident at the facility since 5/2/2012 and was recently admitted to the services of Hospice as of 10/25/2017.

On 3/1/18 at 11:51 AM, an interview was

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conducted with the MDS Coordinator. She reviewed the areas for prognosis and hospice services and stated she did not know how she missed coding those areas. She stated the significant change assessment had been done since Resident #278 had become a hospice resident.

On 3/1/18 at 12:28 PM, an interview was conducted with the Director of Nursing who stated she expected the MDS to be coded accurately.

6. Resident #53 was admitted to the facility on 4/23/13 with multiple diagnoses including Alzheimer's disease. The significant change in status Minimum Data Set (MDS) assessment dated 1/20/18 indicated that Resident #53 had no falls since admission/reentry or prior assessment. The prior assessment was a 90 day assessment dated 11/28/17.

Review of the incident reports revealed that Resident #53 had a fall with no injury on 12/17/17. The report indicated that Resident #53 was noted sitting on her buttock on the left side of the bed on the floor.

On 3/1/18 at 11:58 AM, the MDS Nurse was interviewed. She verified that Resident #53 had a fall on 12/17/17 and the MDS assessment dated 1/20/18 should have been coded with a fall but it was not. She added that the fall section was not accurate.

On 3/1/18 at 12:28 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS assessments to be accurate.

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F 656	Continued From page 14	F 656		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate	F 656		3/29/18

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F 656	Continued From page 15 entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interviews, the facility failed to have comprehensive care plans in place for hospice (Resident #278) and indwelling urinary catheter (Resident #39) for 2 of 22 sampled residents. The facility also failed to implement the care plan intervention for every 15-minute checks for a resident who was at risk for elopement (Resident #39). The findings included: 1. Resident #39 was admitted to the facility 4/1/10. Cumulative diagnoses included, in part cerebrovascular accident with right sided weakness and expressive aphasia (partial loss of the ability to produce language) and traumatic compartment syndrome of left lower extremity (trauma that causes a severe high pressure in the compartment which results in insufficient blood supply to the muscles and nerves). A Quarterly Minimum Data Set (MDS) dated 1/2/18 indicated Resident #39 had good short-term memory, impairment of long term memory and was moderately impaired with daily decision-making skills. No moods were noted. Rejection of care occurred 4-6 days. No wandering was noted during the assessment period. Extensive assistance was needed with bed mobility, transfers, dressing, toilet use, personal hygiene and bathing. Resident #39 required limited assistance with locomotion on and off the unit.	F 656	F656 1. Resident #278 no longer resides in the facility. Resident #39 remains at baseline. Nurses assigned to monitor Resident #39 in response to the potential for elopement as noted as an intervention in the care plan on 2-17-18, 2-18-18, 2-24-18, and 2-25-18 were re-educated to the care plan interventions specific to fifteen (15) minute safety checks and the expectation of compliance with the same. Resident #53□s care plan for an indwelling catheter was activated by the MDS nurse on 2-18-18. 2. A facility wide audit was conducted and completed by the Director of Nursing by 3-19-18 evaluating and confirming that a. Current residents with elopement risk have responsive care plans and interventions activated ensuring that compliance with the same exists; b. Current hospice residents have responsive care plans and interventions activated and that compliance with the same exists; c. Current residents with indwelling catheters have responsive care plans and interventions activated and evidence that compliance with the same exists. The results of the audit confirms 1) 100%	

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F 656	Continued From page 16 A Wander assessment dated 2/2/18 noted Resident #39 was a wander/elopement risk and his care plan had been updated. A care plan dated 1/3/18 and revised 2/2/18 stated Resident #39 was an elopement risk due to traumatic compartment syndrome and depressive disorder related to impaired safety awareness. Interventions included, in part, to increase monitoring when resident was sitting on the front porch. Resident #39 triggered for eloping when he experienced increased agitation. His behavior was de-escalated by one to one staff interaction and redirection. A notation was added to the care plan on 2/2/28 -- Resident #39 showed a desire to leave the facility. Interventions added on 2/2/18 included, in part, every 15 minute checks. Increase staff monitoring and redirection by staff as needed. A nursing note dated 2/5/18 at 9:49 AM stated the following: late entry: note text: On 2/2/18 Resident #39 was sitting on the front porch and staff observed resident rolling himself off the front porch. Staff immediately went to redirect resident. Resident #39 was noted with increased agitation and pointing to the road. Staff told Resident #39 that was not safe and continued to redirect Resident #39 with one to one intervention until he wheeled himself back in the building. Every 15-minute checks and increased monitoring by the staff was initiated at that time. A nursing note dated 2/5/18 at 9:56 AM stated the following: Follow up with the weekend supervisor with no concerns with the resident this weekend. No attempts to leave and has voiced no concerns related to wanting to leave. Resident #39	F 656	compliance with elopement risk care plans and interventions, 2) 100% compliance with hospice care plans and interventions for residents receiving hospice services, and 3) 100% compliance with indwelling catheter care plans and interventions for residents with indwelling catheters. 3. The facility has reviewed its□ policy on care planning. No revisions are needed at this time. MDS nurse, DON, ADON, Unit Manager, and charge nurses who are responsible for initiating, updating care plans and who are responsible for completing CAA□s, determining the decision to care plan, developing and ensuring care plan interventions are implemented are re in serviced to the same by the Staff Development nurse or Director by 3-29-18. Staff will not be scheduled or assigned to work until they attend the inservice after 3-29-18. 4. The Quality Assessment and Assurance (“QAA”) team Coordinator and its members as noted below (MDS nurse, DON, Unit Manager, Charge Nurse) will be responsible for the ongoing monitoring of this process through audits as follows the 1) Weekly the MDS nurse will review all Care Area Assessments (“CAA’s”) while finalizing MDS for residents’; ensuring the presence of generated care plans for the same, as appropriate. 2) Weekly tThe MDS nurse will confirm the presence of completed care plans related to CAA’s along with compliance with the care plan interventions during the	

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F 656	Continued From page 17 remained on every 15-minute checks and the care plan had been updated. A behavior note dated 2/19/18 at 3:14 PM stated Resident #39 experienced increased anxiety in the afternoon and was wanting to leave. Resident provided one to one supervision during increased anxiety. Resident swinging fist at staff and yelling "No" when trying to make aware of safety. Resident #39 remained on every 15-minute safety checks. A review of every 15- minute safety checks completed by nursing staff since 2/2/18 revealed there were no safety check sheets for 2/17/18, 2/18/18, 2/24/18 and 2/25/18. The Director of Nursing stated she could not find the safety check sheets for those dates. On 2/27/18 at 5:04 PM, a telephone interview was conducted with Nurse #3 who worked 7:00 PM-7:00 AM on 2/17/18, 2/18/18, 2/24/18 and 2/25/18. She stated she completed every 15-minute check sheets for 2/17/18, 2/18/18, 2/24/18 and 2/25/18 and she thought the every 15-minute check sheets for Resident #39 was still on the nursing clipboard or may have been filed in the front of the medical record under nursing notes. On 2/28/18 at 9:06 AM, a telephone interview was conducted with Nurse #4 who stated the weekend after resident went outside (2/2/18), she was not aware or told that Resident #39 was on every 15-minute checks until the Director of Nursing called her on Monday 2/4/18. She said she reviewed the nursing notes and there was not a note stating resident had tried to leave or that he was on every 15-minute checks. Nurse #4	F 656	resident's quarterly care conference, and 3) monthly the DON, ADON, unit manager or charge nurse will review up to 30% of completed care plans the presence of care plans in accordance with CAA worksheets which are reflective of the resident's current condition and that interventions are appropriate. This shall occur monthly for three (3) months. All findings will be promptly addressed with revisions as needed and follow-up will occur with employees who were assigned core intervention tasks for which there were noted variances. All findings and responsive action will be reported to the QAA team during routine meetings. After three (3) months, the QAA team will determine the frequency of ongoing audits which will occur not less than quarterly for one (1) year. Date of Compliance: 3-29-18	

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stated Resident #39 was not on every 15- minute checks 2/17/18, 2/18/18, 2/24/18 and 2/25/18 but staff charted his behaviors in the nursing notes. She said Resident #39 and all the other residents who sit outside the door in the front area of the facility did not go to that area on weekends but sat in the dining room or went out to the smoking area just outside of the dining room.

On 2/28/18 at 10:04 AM, an interview was conducted with the Director of Nursing who stated she expected nursing staff to follow the care plan intervention of every 15-minute checks for Resident #39 and every 15- minute checks should have been completed on 2/17/18, 2/18/18, 2/24/18 and 2/25/18.

2. Resident #278 was admitted to the facility on 5/2/12. Cumulative diagnoses included Alzheimer ' s disease.

A review of physician orders revealed an order dated 10/25/17 that stated admit to community hospice.

A Significant Change Minimum Data Set (MDS) Assessment dated 11/7/17 indicated Resident #278 had short and long-term memory impairment and was moderately impaired in daily decision making.

A Care Area Assessment for activities of daily living dated 11/7/17 stated, in part, Resident #278 had been a resident at the facility since 5/2/2012 and was recently admitted to the services of Hospice as of 10/25/2017.

A review of the care plan for Resident #278 revealed there was no care plan for hospice.

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On 3/1/18 at 12:23 PM, an interview was conducted with the MDS Coordinator. She stated she was responsible for the care plan for Resident#278. She reviewed the care plan and stated a care plan for hospice services should have been completed for Resident #278.

On 3/1/18 at 12:28 PM, an interview was conducted with the Director of Nursing. She said she expected staff to implement a care plan for hospice if Resident #278 had received hospice services.

3. Resident #53 was admitted to the facility on 4/23/13 with multiple diagnoses including Urinary Retention. The significant change in status Minimum Data Set (MDS) assessment dated 1/20/18 indicated that Resident #53 had severe cognitive impairment and she had an indwelling catheter. The care area assessment (CAA) dated 1/20/18 indicated that the use of the indwelling catheter would be addressed in the care plan.

The care plan of Resident #53 dated 1/24/18 was reviewed. There was no care plan problem, goal or approaches developed for the use of the indwelling catheter.

On 2/27/18 at 12:30 PM and at 3:05 PM, Resident #53 was observed in bed. She was observed to have a urinary catheter attached to a privacy bag.

On 3/1/18 at 11:58 AM, the MDS Nurse was interviewed. She verified that Resident #53 had an indwelling urinary catheter. She reviewed the care plan and stated that she missed to develop a care plan for the use of the indwelling catheter.

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F 656	Continued From page 20 On 3/1/18 at 12:28 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected a care plan developed when a resident has an indwelling catheter.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview, the facility failed to provide restorative dining services as ordered for a resident with unintended significant weight loss for 1 of 5 residents (Resident #60) reviewed for nutrition. The findings included: Resident #60 was admitted to the facility on 10/25/17 with multiple diagnoses that included pneumonitis due to inhalation of food and vomit and dementia without behavioral disturbance. The admission Minimum Data Set (MDS) assessment dated 11/1/17 indicated Resident #60's cognition was moderately impaired. He had no behaviors and no rejection of care. Resident #60 was assessed as requiring the limited assistance of 1 staff with eating. He was receiving Speech Therapy (start date 10/26/17). A Standards of Care (SOC) note dated 12/14/17 indicated Resident #60's current body weight of 198.9 pounds (12/14/17) triggered him with a	F 658	F658 1. Resident #60 has been re-evaluated for the Restorative Nursing Program (RNP) -dining. Fortified foods with meals has been ordered in response to his weight loss was ordered on March 1,2018. Resident #60 has been discharged from the RNP-dining program. Resident #60 now receives dining supervision and cueing in the secured Memory Care unit. His nutritional intake remains 100 percentage (%) while dining in the Memory Care unit. 2. A facility wide audit was completed by the Restorative Nurse on 3-14-18 of all current residents with orders for restorative dining ensuring that residents with orders were attending restorative dining as ordered and/or if the resident declined or was not in attendance, the MD and RD were notified of the same. The audit confirms two (2) out of four (4)	3/29/18

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F 658	Continued From page 21 trend of significant weight loss of 17 pounds (7.9%) in one month. A physician's order dated 12/29/17 indicated restorative dining services at all meals for Resident #60 per therapy referral. A physician's order dated 1/1/18 indicated Resident #60 was moved to the memory care unit. An SOC note dated 1/11/18 indicated Resident #60's current body weight was 195.0 pounds (1/11/18). This weight was identified as a significant loss of 10.2% in 1 month and 10.43% in 3 months. Resident #60 was noted as attending the restorative dining program. A Registered Dietician (RD) note dated 1/17/18 indicated Resident #60 had significant weight loss in the past month and the past 3 months. Resident #60 was noted as attending the restorative dining program. An SOC note dated 2/1/18 indicated Resident #60's current body weight was 190.2 pounds (1/28/17). This weight was identified as a significant loss of 15.7% since 10/29/17 (225.6 pounds). An RD note dated 2/14/18 indicated Resident #60's current body weight was 186.4 pounds. This weight was identified as a significant loss in three months. Resident #60 was noted as attending the restorative dining program. An observation was conducted of the lunch meal on the memory care unit on 2/26/18 at 12:30 PM. Resident #60 was observed eating his lunch at a	F 658	current residents participating in RNP-dining for whom RNP-dining physician order revisions were implemented. One (1) of four (4) residents has experienced weight loss during the RNP-dining program. Communication with the attending physician, resident representative and the dietitian related to the weight loss has occurred with documentation. This resident has a care plan for the potential for weight loss with all interventions activated as written. Dietitian reassessed the resident on March 14, 2018. 3. A review of the facility□s 1) RNP -dining program and related documentation, 2) physician notification, and 3) unplanned weight loss process and responsive communication with the physician, responsible party and dietitian in response to unplanned weight loss has been reviewed. No revisions are needed at this time. All licensed nurses (FT, PT, and PD) shall be re in serviced by the Staff Development nurse or Director of Nursing to the above processes. Staff will not be scheduled or assigned to work until they attend the inservice. 4. The Quality Assessment and Assurance (“QAA”) Coordinator and QAA team members as noted below (Restorative Nurse, DON, Unit Manager, Dietitian, MDS nurse) will be responsible for the ongoing monitoring of this process through the 1) Weekly RNP-dining observation & documentation reviews by the Restorative Nurse , DON, or Unit	

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F 658	Continued From page 22 table in the common area of the memory care unit. He required assistance with set up and encouragement to continue eating throughout the meal. An interview was conducted with Nurse #1 on 2/28/18 at 3:30 PM. She stated she worked the 3:00 PM to 11:00 PM shift on the memory care unit. She reported she was familiar with Resident #60. She stated he had not attended the restorative dining program since he was moved to the memory care unit. An interview was conducted with Nurse #2 on 2/28/18 at 3:35 PM. She stated she worked the 7:00 AM to 3:00 PM shift on the memory care unit. She reported she was familiar with Resident #60. She stated he had not attended the restorative dining program since he was moved to the memory care unit. An interview was conducted with Restorative Nursing Assistant (NA) #1 on 2/28/18 at 3:37 PM. She stated Resident #60 previously attended the restorative dining program. She indicated he had not attended the program since he moved to the memory care unit (1/1/18). An observation was conducted of the dinner meal on the memory care unit on 2/28/18 at 5:20 PM. Resident #60 was observed eating his dinner at a table in the common area of the memory care unit. An observation was conducted of the breakfast meal on the memory care unit on 3/1/18 at 8:30 AM. Resident #60 was observed eating his breakfast at a table in the common area of the memory care unit.	F 658	Manager confirming that all residents with orders for restorative dining are attending the RNP-dining program and are participating in the program as ordered, 2) Weekly reviews by the Restorative Nurse, DON or Unit Manager of RNP-dining progress notes which reflect a resident's attendance, participation, meal consumption documentation. 3) Weekly review of weights by the Dietitian shall continue; ensuring prompt evaluation and interventions as needed for significant weight changes; 4) Quarterly reviews by Restorative Nurse and MDS nurse of the RNP-dining care plans and related interventions; ensuring compliance with the RNP-dining orders. All findings will be promptly addressed and reported to the QAA team during routine meetings. After three (3) months, the QAA team will determine the frequency of ongoing audits however the audits will occur not less than quarterly for one (1) year. Date of Compliance: 3-29-18	

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F 658	Continued From page 23	F 658		

An interview was conducted with the Nutritionist on 3/1/18 at 8:40 AM. She stated she had been coming to the facility once per week and as needed for approximately 1 year. She reported she was familiar with Resident #60. She indicated he was referred to the restorative dining program related to significant weight loss and the need for increased supervision. The observations on 2/26/18, 2/28/18, and 3/1/18 of Resident #60 that revealed he was no longer attending the restorative dining program was shared with the Nutritionist. The interviews with Nurse #1, Nurse #2, and Restorative NA #1 that revealed Resident #60 had not attended the restorative dining program since he had moved to the memory care unit (1/1/18) was reviewed with the Nutritionist. She stated she was unaware Resident #60 was no longer attending the restorative dining program. She indicated she expected to be informed if a resident was discontinued on restorative services. The Nutritionist reported this could have been reported to her verbally or by including a physician's order in Resident #60's medical record that discontinued restorative dining services.

A phone interview was conducted with the RD on 3/1/18 at 8:55 AM. She stated she came to the facility about twice per month. She reported she was unable to recall any specific details about Resident #60. The RD was asked how she was kept informed of residents who were on restorative dining services. She explained that she reviewed the physician's orders to determine if a resident was attending restorative dining services. The RD indicated there was a physician's order written when restorative

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F 658	Continued From page 24 services commenced and when they were discontinued. An interview was conducted with the Director of Nursing on 3/1/18 at 12:30 PM. She indicated she expected restorative dining services to be provided as ordered. She additionally indicated if restorative dining services were going to be discontinued then she expected a physician's order to be in the resident's medical record. The DON explained that residents were normally discontinued from restorative dining services if they were moved to the memory care unit as this unit provided an increased amount of supervision.	F 658		
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 observation, medical record review, resident and staff interviews, the facility failed to evaluate and complete a smoking assessment for two of three sampled residents who smoked (Resident #33 and #70). The findings included: 1. Resident #33 was admitted to the facility 12/14/17. An Admission Minimum Data Set (MDS) dated 12/26/17 indicated Resident #33 was cognitively intact.	F 689	F689 1. A smoking assessment was completed by the Unit Manager for Resident #33 on 2-27-18 and will occur quarterly hereafter as long as the resident continues to smoke. A smoking assessment was completed by the Unit Manager for Resident #70 on 2-27-18 and will occur quarterly hereafter as long as the resident continues to smoke.	3/29/18

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F 689	Continued From page 25 On 2/27/18 at 2:34 PM, Resident #33 was interviewed and stated he smoked when he wanted. He stated he kept his own cigarettes and lighter and locked them up when he wasn ' t using them. Resident #33 stated he had been smoking at the facility about a month. Resident #33 was observed to have his cigarettes and lighter in his hands during the interview. At the end of his interview, Resident #33 said he was going out to smoke. A review of the Resident tobacco assessments dated 12/14/17, 1/15/18, 1/23/18 and 2/6/18 indicated resident #33 was a non-smoker. There was no Resident tobacco assessment completed when Resident #33 began smoking at the facility. On 2/27/18 at 5:22 PM, an interview was conducted with Nurse #5. She stated she completed the Resident tobacco assessment forms on admission, quarterly and if there were any changes with any of the smokers. She stated she had observed Resident #33 outside smoking and it had not dawned on her to do another tobacco assessment. On 2/28/18 at 2:10 PM, an interview was conducted with the Director of Nursing who stated her expectation was for a smoking assessment to be done on admission, if there was a change in status for a resident and if a resident in the facility began smoking. 2. Resident #70 was admitted to the facility 12/14/17. Cumulative diagnoses included: cerebral infarction, chronic obstructive pulmonary disease and history of malignant neoplasm (cancer) of the upper right lobe of the lung. An admission MDS dated 12/21/17 indicated	F 689	2. An observation of residents smoking as well as a facility wide medical record review was completed by Medical Records Technician 3-15-18 for all current residents identifying 1) those who smoke confirming the presence of a smoking assessment performed on admissions or upon the initiation of smoking, upon change of condition and quarterly, and 2) the level of smoking supervision, if needed and that that level of supervision is being provided. The audit findings note seven (7) current residents are “smokers”. Of the seven (7) smoking residents, all have been assessed to be independent with smoking. 100% of residents who smoke have been observed on 3-15-18 confirming safe smoking practices. All quarterly smoking assessments have been updated. 3. The facility has reviewed its smoking policy dated 2-28-18. No revisions are needed at this time. All licensed nurses (FT, PT, or PD) will be re in-serviced on the smoking policy and the need to conduct smoking assessments per policy by the Staff Development Nurse or Director of Nursing by 3-29-18. Staff will not be scheduled or assigned to work until they attend the inservice after 3-29-18. 4. The Quality Assessment and Assurance (“QAA”) Coordinator and the QAA members as noted below (Restorative Nursing Assistant, Nursing Assistant, DON, Unit Manager, Charge	

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F 689	Continued From page 26 Resident #70 was cognitively intact. The Resident tobacco assessment dated 12/14/17 stated Resident #70 said she smoked but was not going to smoke while at the facility. There were no further Tobacco assessments. On 02/27/18 at 3:30 PM, an interview was conducted with Resident #70 who stated she was a smoker, smoked independently and kept her cigarettes and lighter in her coat pocket. She stated, when she first came to the facility, she told them she was a smoker but her family member "overrode" what she said and told them she was not going to smoke. Resident #70 said she began smoking two to three weeks ago. At the end of her interview, Resident #70 ambulated down the hall pushing her wheelchair and went to the smoking area to smoke. On 2/27/18 at 5:22 PM, an interview was conducted with Nurse #5. She stated she had completed the Resident tobacco assessment for Resident #70 on admission. Nurse #5 said she was not aware that Resident #70 was now smoking. She said, normally, the staff on the floor would tell her if a resident was smoking. Nurse #5 stated she would expect a Resident Tobacco assessment to be completed when a resident began smoking at the facility. On 2/28/18 at 2:10 PM, an interview was conducted with the Director of Nursing who stated her expectation was for a smoking assessment to be done on admission, if there was a change in status for a resident and if a resident in the facility began smoking.	F 689	Nurse, Quality Assurance Coordinator)will be responsible for the ongoing monitoring of this process through the 1) twice weekly (including week days and weekends) for four (4) weeks then weekly for three (3) months observations of resident's smoking will occur by a restorative nursing assistant or assigned nursing assistant; ensuring that the resident smoking list is current and smoking assessments are performed in accordance with the policy. 2) twice weekly for four (4) weeks then weekly for three (3) months the DON, Unit Manager or Charge Nurse shall review the smoking list ensuring that smoking assessments are performed per policy. 3) Weekly Care plan conference reviews will be conducted the MDS nurse or Quality Assurance Coordinator inquiring about the residents smoking practices. This inquiry will confirm the presence of timely smoking assessments and smoking care plans with appropriate interventions. All findings will be promptly addressed and with responsive action reported to the QAA team during routine meetings. After two (2) quarters, the QAA team will determine the frequency of ongoing monitoring however the observations will occur not less than quarterly for one (1) year. Date of Compliance: 3-29-18	
F 744	Treatment/Service for Dementia	F 744		3/29/18

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F 744 SS=D	Continued From page 27 CFR(s): 483.40(b)(3)	F 744		

§483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.
This REQUIREMENT is not met as evidenced by:
Based on record review, staff and resident interview, the facility failed to implement person centered care planned interventions to address the needs of a resident with dementia for 1 of 3 residents (Resident #14) reviewed for dementia care. The findings included:

Resident #14 was admitted to the facility on 3/26/15 and most recently readmitted on 9/22/16 with diagnoses that included dementia with behavioral disturbance, anxiety disorder, bipolar disorder, major depressive disorder, and psychosis.

The quarterly Minimum Data Set (MDS) assessment dated 11/23/17 indicated Resident #14 had severely impaired cognition. He was assessed with no behaviors and no rejection of care. Resident #14 was dependent on 2 or more staff with bed mobility, transfers, toileting, personal hygiene, and bathing. He was dependent on 1 staff for assistance with locomotion on/off the unit and with dressing. He required the limited assistance of 1 staff for eating.

The plan of care for Resident #14 included, in part, the following focus areas that were initiated on 11/24/17 and last reviewed on 1/11/18:

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1. Resident #14 remains at baseline with ongoing interventions in place to present a calm approach during periods of agitation. An observation of staff and resident interaction on March 15, 2018 confirms compliance with the care plan interventions for his dementia/impaired psychosocial process.
2. A facility wide audit was completed by the Staff Development Nurse and the Assistant Director of Nursing on 3-21-18 of all current residents with diagnoses of Dementia has been conducted; ensuring
a. The presence of a care plan complete with interventions;
b. Observations between the residents with Dementia and caregiver confirm compliance with the interventions; and
c. Interviews with caregivers routinely assigned to these residents confirm he/she understands the appropriate and care planned interventions when approaching someone with Dementia.
The audit results confirm that forty-six (46) residents currently carry a diagnosis of Dementia or related disorders. All residents with a diagnosis of Dementia have person centered care plans addressing the diagnosis with responsive

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F 744	Continued From page 28 - Resident #14 was at risk for impaired psychosocial process. The interventions included: allow resident time to answer questions and to verbalize feelings, perceptions, and fears when agitated; when conflict arises, remove resident to a calm safe environment and allow to vent/share feelings. - Resident #14 was at risk of developing complications associated with decreased Activities of Daily Living (ADL) performance related to a diagnosis of dementia. The interventions included: redirect resident as needed; reassure resident when confusion has increased; verbal cues and reminders to assist resident with daily orientation. - Resident #14 displayed unsettled/fidgety behaviors at times and was combative with staff at times during care. The interventions included: anticipate and meet the resident ' s needs; caregivers to provide opportunity for positive interaction, attention, stop and talk to resident as passing by; explain all procedures to the resident before starting and allow the resident time to adjust to changes; approach/speak in a calm manner, divert attention, remove from situation and take to alternate location as needed. A 24-hour initial report dated 1/22/18 indicated an allegation of staff to resident abuse. The allegation description indicated Resident #7 reported to staff that Resident #14 was talked to harshly by Nursing Assistant (NA) #1. NA #1 was suspended pending the outcome of the investigation. A statement made by Resident #7 (11/9/17 annual MDS indicated his cognition was intact) to the Administrator on 1/22/18 at 1:00 PM was reviewed. This was a verbal statement that had	F 744	interventions. Eight (8) resident care plans are being enhanced to more descriptively address interventions. These care plan enhancements will be reviewed with the certified nursing assistants (“CNA’s”). 3. A review of the facility’s policies on Abuse and Reporting the Suspicion of Abuse was reviewed. No revisions are needed to these policies. Abuse and Reporting the Suspicion of Abuse/Crime continues to be included in general Orientation, annually thereafter and as needed. All Nursing staff (FT, PT, and PD) will be reeducated to the above policy and facility expectation of compliance with the same by the Staff Development nurse by 3-29-18. Staff will not be scheduled or assigned to work until they attend the inservice after 3-29-18. 4. The Quality Assessment and Assurance (“QAA”) Coordinator and the QAA members as noted below (DON, ADON, Social Services Director, LNHA, MDS nurse) will be responsible for the ongoing monitoring of this process through the 1) Weekly during MDS assessment completion and corresponding care plan conferences, the MDS nurse will inquire about the resident’s care and treatment; ensuring that resident care delivery is free from allegations of abuse. 2) Monthly resident council meetings in which resident rights are reviewed and complaints are logged and processed by the Activity Coordinator and overseen by the licensed nursing	

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F 744	Continued From page 29	F 744		

been typed and printed as a hard copy document. The document indicated Resident #7 said he wanted to report instances of verbal abuse. He stated, "My roommate [Resident #14] has been talked to very harshly by [NA #1]. She has no patience for him. She is loud with him and fusses at him and even threatens him ... she gets impatient when she is feeding him because he moves his arms around. She will say things like, ' you either quit or you aren ' t getting anything to eat. ' " Resident #7 reported this type of behavior was witnessed on multiple occasions stating, "it ' s all the time".

The facility ' s investigation into the 1/22/18 allegation of staff (NA #1) to resident (Resident #14) abuse related to Resident #14 included a hard copy questionnaire for facility staff that asked the following question:
"Has any resident or staff expressed concerns about [3:00 pm to 11:00 pm] staff or have you heard staff members talking harshly or threatening to residents?"
A review of these questionnaires (all undated) revealed NA #2 responded by writing "I would rather not get involved" and NA #5 responded by writing "I have witnessed [NA #1] using disrespectful tone of voice several times."

The 5-working day report dated 1/27/18 indicated the allegation of staff (NA #1) to resident (Resident #14) abuse reported by Resident #7 was investigated by the Director of Nursing (DON) and was unsubstantiated. The report indicated Resident #14 was unable to give a statement due to his cognitive impairment. Resident #14 had no change in mood or behavior. Alert residents on the unit were interviewed with no concerns noted. Staff

administrator (“LNHA”), 3) Weekly (with observations on all shifts and days including week-ends) for three (3) months, Resident Care/Observation Summary tool to be completed by the Social Services Director or Quality Assurance Nurse or charge nurse; ensuring that care delivery is free from allegations of abuse. All findings will be promptly addressed and with responsive action reported to the QAA team during routine meetings. After two (2) quarters, the QAA team will determine the frequency of ongoing monitoring however the observations will occur not less than quarterly.

Date of Compliance: 3-29-18

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interviews revealed one concern related to NA #1 stating that her tone was "disrespectful". NA #1 denied the allegation. NA #1 was to be re-educated on customer service and abuse and neglect.

A psychosocial note dated 1/27/18 indicated Resident #14 had no change in mood or behavior.

A Psychiatric Nurse Practitioner (PNP) note dated 2/5/18 indicated Resident #14 was seen for a follow up visit. Resident #14 had a history of dementia and agitation. His dementia was described as significant with no meaningful conversation. No new concerns were identified and no adjustments were made to his treatment.

An interview was conducted with the Administrator on 2/27/18 at 12:45 PM. The statement made by Resident #7 on 1/22/18 at 1:00 PM regarding the allegation of NA #1 abusing Resident #14 was reviewed with the Administrator. The Administrator indicated she was familiar with Resident #7 and she believed him to be reliable.

An interview was conducted with NA #2 on 2/27/18 at 2:08 PM. She indicated she was familiar with Resident #7 and she believed he was alert, oriented, and reliable. She also indicated she was familiar with Resident #14. She stated Resident #7 became combative at times if he was agitated. The hard copy questionnaire (undated) that asked if any resident or staff expressed concerns about the 3:00 PM to 11:00 PM staff or if she had heard staff members talking harshly or threatening to residents was reviewed with NA #2. She confirmed she had

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F 744	Continued From page 31	F 744		

responded to the questionnaire by writing "I would rather not get involved". NA #2 was asked to explain why she had not wanted to get involved. She indicated she thought the questionnaire was related to NA #1 ' s interactions with residents and staff as she had heard other staff members talking about the allegation. She stated she had worked with NA #1 on previous occasions. She reported she believed NA #1 ' s personality sometimes came off to others as being "mean". She explained that NA #1 could be "short" when speaking with both staff and residents. NA #2 described "short" as abrupt/curt responses. She further explained that she believed this type of interaction from NA #1 was unintentional and was just part of her personality. NA #2 stated because she had thought NA #1 ' s behavior was unintentional she had not wanted to get involved and she had not personally reported this information to any of her supervisors.

An interview was conducted with Resident #7 on 2/27/18 at 3:10 PM. During this interview, Resident #7 was alert and oriented. He reiterated the information in his 1/22/18 statement. Resident #7 indicated Resident #14 required assistance with feeding. He reported Resident #7 was combative at times and would sometimes swing his arms around when being provided with care. He stated on more than one occasion he observed Resident #14 swinging at NA #1 while she was feeding him and NA #1 told Resident #14, "If you don ' t stop I ' m not going to feed you." Resident #7 indicated he had initially not reported NA #1 ' s behavior to any other staff members, but after it had reoccurred on a few occasions he felt it was his responsibility to report it as Resident #14 was unable to speak for himself.

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An interview was conducted with NA #3 on 2/27/18 at 3:25 PM. She indicated she was familiar with Resident #7 and she believed he was alert, oriented, and reliable. She stated she was not very familiar with NA #1.

An interview was conducted with NA #4 on 2/27/18 at 3:30 PM. She indicated she was familiar with Resident #7 and she believed he was alert, oriented, and reliable. She also indicated she was familiar with Resident #14. She stated Resident #14 became combative at times if he was agitated. She reported when Resident #14 became agitated she attempted to provide calm speech and reassurance to him. She stated if those interventions were unsuccessful she ensured the resident was safe and then left the room and returned a little later. NA #4 reported she had worked with NA #1 on a few occasions. She indicated she had not witnessed any inappropriate interactions between NA #1 and any residents.

An interview was conducted with NA #5 on 2/27/18 at 3:45 PM. She indicated she was familiar with Resident #7 and she believed he was alert, oriented, and reliable. The hard copy questionnaire (undated) that asked if any resident or staff expressed concerns about the 3:00 PM to 11:00 PM staff or if she had heard staff members talking harshly or threatening to residents was reviewed with NA #5. She confirmed she had responded to the questionnaire by writing "I have witnessed [NA #1] using disrespectful tone of voice several times." NA #5 was asked to expand upon what types of interactions she had witnessed. She stated NA #1 spoke to residents in a disrespectful tone and was very loud. NA #5

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reported NA #1 approached residents by telling them what they were going to do rather than asking them. She explained that an example of this was NA #1 telling a resident, "you ' re gonna get your bath today" rather than asking the resident if they were ready for their bath. NA #5 stated that NA #1 used "threats" to try to get residents to cooperate with her. When asked to explain what type of "threats", she stated she had witnessed NA #1 say things like "if you don ' t eat now I ' m going to feed you" and "I ' m going to make you get up if you don ' t eat this." NA #5 indicated she felt this type of interaction with residents was inappropriate, disrespectful, and was not in line with how the facility trained their staff to interact with residents. She indicated after she had completed this hard copy questionnaire the DON interviewed her and asked her for additional information. She reported she told the DON the same examples she provided during this interview.

A phone interview was conducted with NA #1 on 2/27/18 at 4:16 PM. She stated she was familiar with Resident #7 and she believed he was alert, oriented, and reliable. When NA #1 was asked about the allegation of abuse towards Resident #14 that was made by Resident #7 on 1/22/18 she stated she had to get off of the phone and requested to be called back on the following afternoon (2/28/18).

An interview was conducted with the DON on 2/27/18 at 4:48 PM. The DON was asked to explain the findings of her investigation into the allegation of staff (NA #1) to resident (Resident #14) abuse made by Resident #7 on 1/22/18. She stated Resident #7 was alert, interviewable,

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and reliable. She indicated she believed his report of the interactions between NA #1 and Resident #14 was accurate. The DON stated following the allegation made by Resident #7 she had asked staff members to complete a hard copy questionnaire that asked if any resident or staff expressed concerns about the 3:00 PM to 11:00 PM staff or if they had heard staff members talking harshly or threatening to residents. She indicated there was only one NA (NA #5) who indicated she had witnessed this type of behavior from staff (NA #1). She stated she interviewed NA #5 and she had reported NA #1 spoke to residents in an "inappropriate way." She explained that NA #5 had not provided any specific examples, but she had indicated NA #1 ' s tone of voice was not appropriate and she felt this was not how staff were supposed to speak to residents. The DON reported that NA #5 had not stated NA #1 was abusive to residents.

This interview with the DON continued. She stated that in the past, she had one other allegation of staff to resident abuse that involved NA #1. She reported this was a similar allegation about speaking harshly and inappropriately to residents. She stated the allegation was made by a resident who had combative behaviors, verbal behaviors, a diagnosis of Alzheimer ' s, and an MDS cognitive assessment of severely impaired. She reported she had no interviewable residents involved in that allegation and no staff or other residents were able to corroborate the information. The DON explained that although she was unable to substantiate the allegation of abuse, she felt there was an issue with NA #1 ' s customer service skills and with her ability to interact appropriately with cognitively impaired residents with behaviors.

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F 744	Continued From page 35 A phone call was made to NA #1 on 2/28/18 at 1:33 PM as she had requested to complete her phone interview that afternoon. NA #1 had not answered the phone. A phone message was left, but the phone call as not returned. A follow up interview was conducted with the DON on 3/1/18 at 12:30 PM. She stated it was her expectation that person-centered care planned interventions were consistently implemented for residents with dementia. She indicated she expected staff to implement the skillsets they were taught during their dementia training. She explained this this included speaking slowly and calmly, explaining procedures before taking action, allowing the resident time to adjust to changes, and providing reassurance when a resident was agitated. The DON indicated she believed NA #1 had not implemented these care planned interventions consistently for Resident #14.	F 744		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and	F 755		3/29/18

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F 755	Continued From page 36 biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, observation and Physician, resident, pharmacy and staff interview, the facility failed to acquire and to administer the pain medication as ordered for 1 of 2 sampled residents reviewed for pain (Resident #63). Findings included: Resident #63 was admitted to the facility on 11/21/17 with multiple diagnoses including displaced intertrochanteric fracture of the left femur and was readmitted on 1/12/18 after revision of the left hip fracture. The admission Minimum Data Set (MDS) assessment dated 11/28/17 indicated that Resident #63's cognition was intact and she had received scheduled pain medication regimen. Resident #63's care plan dated 11/24/17 was	F 755	F755 1. Pain management medications for Resident #63 have been successful. The e-box (an interim supply of medications contents have been reviewed and updated to include a sufficient tiered listing of analgesics available to the facility with a physician's order as a short-term alternate as the facility awaits pharmacy delivery. 2. A facility wide audit was completed by the Director of Nursing ("DON") on 3-20-18 of all current residents with orders for medications to treat pain has been conducted to ensure that they are a. received timely from the pharmacy, b. being administered as ordered, c. renewed/resupplied medications in the past 30 days occurred without	

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reviewed. One of the care plan problems was acute/chronic pain related to left hip fracture. The goal was to have no interruption in normal activities due to pain through the review date. The approaches included to administer analgesia as per doctor's order.

Resident #63's doctor's orders were reviewed. On 1/12/18, there was an order for Oxycodone (narcotic pain reliever) 10 milligrams by mouth every 6 hours (12 AM, 6 AM, 12 Noon and 6 PM) for pain. On 2/26/18, there was an order to "hold Oxycodone 10 mgs until it arrives from the pharmacy", an order for one time dose for Tramadol (narcotic pain reliever) 50 mgs for breakthrough pain, an order to change Oxycodone to 10 mgs by mouth to three times a day (6 AM, 2 PM and 10 PM) and to give one time dose of Oxycontin (narcotic pain reliever) 10 mgs. On 2/27/18, there was an order to give one time dose of Oxycontin 10 mgs at 6:45 AM.

On 2/26/18 at 4:31 PM, Resident #63 was observed crying. When interviewed, she stated that she was in pain and her pain medication was not available.

On 2/27/18 at 1:10 PM, Resident #63 was interviewed. She stated that she was still hurting and was scared that she might have withdrawal/cold turkey for not taking her Oxycodone.

The February 2018 Medication Administration Records (MARs) were reviewed. The records revealed that Resident #63 did not received the scheduled Oxycodone on 2/25/18 at 6 PM dose, 2/26/18 at 12 AM, 6 AM, 2 PM and 10 PM doses and on 2/27/18 at 6 AM and 2 PM doses.

interruption of pain management strategies for the resident, and
d. has desired results for the resident.
The audit findings confirm that 100% of residents for which pain medications have been ordered, received the medications from the pharmacy or stock supply in a timely fashion to ensure a timely administration of the same. Physician□s/prescribers of the pain medications administered to the residents who did not experience the desired effect from the same were promptly notified; resulting in a plan of care change. No further action is needed.

3. A review of the facility□s pain management policy, e box policy, and pharmacy dispensing practices specific to schedule II medications requiring a hard copy by the prescribing physician have been reviewed. No revisions are needed to this process currently. The facility will continue to check the daily manifest and pharmacy communication alerting them to the need for hard copy scripts for which they will promptly process.) Daily reviews will be conducted by the evening shift charge nurse and the following day shift charge nurse ensuring that all medications prescribed, authorized, and sent to the pharmacy for dispensing have arrived in a timely fashion. Charge nurses on all shifts shall document pharmacy delivery issues on the Supervisor□s report for prompt follow through. Medication delivery delays will be called to the Supervisor or DON for further facilitation. All licensed nurses (FT, PT,

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F 755	Continued From page 38 On 2/26/18 at 4:40 PM, Unit Manager #1 was interviewed. She stated that Resident #63 ran out of Oxycodone and she had called the pharmacy and the pharmacy stated that a script was needed. A script was obtained from the physician and was faxed to the pharmacy. She stated that Oxycodone should arrive tonight at the 10 PM delivery. She further stated that the physician was informed and she ordered to hold the Oxycodone and to give Tramadol for breakthrough pain. The Unit Manager also indicated that the physician had ordered to give one time dose of Oxycontin for pain. On 2/27/18 at 9:33 AM, the Physician of Resident #63 was interviewed. She stated that she expected the facility to administer medication as ordered and for pharmacy to send medication to the facility in a timely manner. She also verified that she had sent a script to the pharmacy with a wrong dose of Oxycodone and had to send another script. On 2/27/18 at 4:40 PM, Unit Manager #1 was again interviewed. She stated that the Oxycodone did not arrive from the pharmacy last night. She stated that the script that was sent to the pharmacy on 2/26/18 had a wrong dose written (20 mgs instead of 10 mgs). A new script was sent today and the Oxycodone arrived at 3 PM delivery. On 2/28/18 at 4:10 PM, the Pharmacy technician was interviewed. He stated that there was no request from the facility for Oxycodone for Resident #63 before 2/25/18. He stated that on 2/26/18, a script for Oxycodone was received but had a wrong dose (20 mgs) and the order was 10	F 755	and PD) will be reeducated to the same by the Staff Development Nurse by 3-29-18. Staff will not be scheduled or assigned to work until they attend the inservice after 3-29-18. 4. The Quality Assessment and Assurance (“QAA”) Coordinator and the QAA members as noted below (DON, Unit Manager, Charge Nurse, Medication Techs) will be responsible for the ongoing monitoring of this process through the 1) Monday through Friday reviews by the DON and/or Unit Manager on the timely arrival of newly prescribed pain medications from the pharmacy monthly for three (3) months; 2) Daily charge nurse shift discussions with Medication Techs will continue to confirm medication availability for administration and that such has been addressed with the pharmacy. Findings will be addressed with responsive action and reported to QAA during routine meetings. After three (3) months, the QAA team will determine the frequency of ongoing monitoring but shall occur not less than quarterly for one (1) year. Date of Compliance: 3-29-18	

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F 755	Continued From page 39 mgs. A correct script was not received until 2/27/18 and the Oxycodone was sent out on 2/27/18 at 3 PM delivery. On 3/1/18 at 11:04 AM, the Director of Nursing (DON) was interviewed. She stated that the facility's system for acquiring controlled medication from the pharmacy was the staff sent the script to the physician, the physician had to fill out the script and faxed it to the pharmacy. Then the pharmacy sent out the medication to the facility. There was a delay in acquiring the Oxycodone for Resident #63 because the Physician did not complete the script correctly. She further stated that she expected the staff to send the script to the physician way in advance before the medication runs out and to verify with the pharmacy if the script was received.	F 755		
F 865 SS=E	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as	F 865		3/29/18

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F 865	Continued From page 40 a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review, observation and resident and staff interview, the facility's Quality Assurance and Performance Improvement committee (QAPI) failed to maintain implemented procedures and to monitor the interventions that the committee put into place during the 9/21/17 recertification survey. This was for two (2) recited deficiencies (Minimum Data Set (MDS) accuracy and Accidents) which were originally cited on 9/21/17 recertification survey and on the current recertification survey of 3/1/18. The continued failure of the facility during the two federal surveys of record show a pattern of the facility's inability to sustain an effective QAPI program. Findings included: This tag is cross referred to: 1. F641 (MDS Accuracy) - Based on record review and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of falls (Residents #14, #53, and #60), active diagnosis (Resident #40), medications (Resident #32), hospice and prognosis (Resident #278) for 6 of 22 sampled residents. During the recertification survey of 9/21/17, the facility was cited F641 for failure to accurately code the MDS assessments in the areas of prognosis, pressure ulcers, restraints, active diagnoses, falls, incontinence and medications. 2. F689 (Accidents) - Based on observation, medical record review, resident and staff interviews, the facility failed to evaluate and	F 865	F865 1. A review of the past three (3) month Quality Assessment and Assurance (QAA) meeting minutes does not reveal the identification of resident smoking assessment or MDS assessment variances. 2. A review of the Quality Assurance Performance Improvement (QAPI) plan and meetings from the past three months was conducted to evaluate compliance the submitted for the recertification survey dated 9-1-17 as it related to Accidents and MDS assessments. The audit reveals the completion and compliance with the 9-1-17 survey submitted and accepted plan of correction (POC) related monitoring Following the conclusion of the monitoring audits (in accordance with the POC), the facility could have elected to expand the audit sample, continue the audits intermittently, and/or activate new audits to further explore improvement opportunities. 3. Current QAPI plan and related audit tools will be reviewed. Enhanced audit tools are under development and/or have been created and activated to further strengthen the QAPI process. NHA, All department heads, MDS nurse, nurse managers (FT, PT, and PD) will re-inserviced on QAPI enhancements and audit tools by the Staff Development	

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F 865	Continued From page 41 complete a smoking assessment for two of three sampled residents who smoked (Resident #33 and #70). During the recertification survey of 9/21/17, the facility was cited F689 for failure to identify the use of bed rails as a potential accident hazard, review the risk and benefit of bed rails and to obtain informed consent prior to the installation of the bed rails. On 3/1/18 at 11:37 AM, the Administrator and the Director of Nursing (DON) were interviewed on the facility's QAPI program. They were aware that MDS accuracy and Accidents were cited during the recertification survey of 9/21/17. The DON stated that the repeat citation on MDS Accuracy might be due to the MDS Nurse being new to her role as MDS Nurse and she was still learning the process. The DON further stated that she had no system in place to identify and to reassess residents when they started smoking after admission. She stated that she would come up with a plan on how to ensure residents who were assessed not smoking on admission were reassessed weekly x (times) 4 to ensure they have not started smoking.	F 865	Nurse by 3-29-18. Staff will not be scheduled or assigned to work until they attend the inservice after 3-29-18. 4. The Quality Assessment and Assurance (“QAA”) Coordinator and the QAA members which include the LNHA, all department heads, MDS nurse, nurse manager, Medical Director, Dietitian)will be responsible for the ongoing monitoring of this process through the 1) Strategic audit tool roll out 2) Performance of root cause analysis (“RCA”) related to audit tool findings, 3) The development of action plans and Performance Improvement Plans (“PIP’s”) related to findings and 5) comprehensive QAA meetings with reflective minutes . Findings will be addressed promptly and reported to QAA during routine meetings. The QAA team will determine the frequency of ongoing monitoring of all audits, reviews and reports based on compliance with set goals. Date of Compliance: 3-29-18	