STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345563	A. BUILDING _____ B. WING _____	C 05/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAVILION HEALTH CENTER AT BRIGHTMORE	10011 PROVIDENCE ROAD WEST CHARLOTTE, NC 28277

(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 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication	F 636		5/18/18

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

Electronically Signed | 05/18/2018

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F 636	Continued From page 1 with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on staff interviews, and record review, the facility failed to conduct comprehensive assessments to identify and analyze how condition affected function and quality of life related to behavior for 1 of 3 sampled residents with behavior problems (Resident #73). The findings included: Resident #73 was admitted to the facility on 11/03/17 with diagnoses which included dementia. Review of Resident #73's admission Minimum Data Set (MDS) dated 11/10/17 revealed an assessment of intact cognition. The MDS indicated Resident #73 usually understood and	F 636	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F636 Comprehensive Assessment and Timing The plan of correcting the specific	

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F 636	Continued From page 2 understands others with verbal behavior directed toward others. The MDS triggered the Behavioral Symptoms Care Area Assessment (CAA). Review of Resident #73's Behavioral Symptoms CAA dated 11/13/17 revealed no documentation of findings with a description of the problem, contributing factors and risk factor related to behavior. There was no documentation of input from Resident #73 or resident representative. There was no documentation of an analysis of findings supporting the decision to proceed or not to proceed to the care plan. Interview with the social worker on 05/03/18 at 8:58 AM revealed she met with Resident #73 and a family member regarding aggressive verbal behavior. The social worker reported she did not document a behavioral comprehensive assessment. He social worker could not provide a reason for the lack of assessment. Interview with the Director of Nursing (DON) on 05/03/18 at 09:41 AM revealed Resident #73's Behavioral Symptoms CAA did not contain a comprehensive assessment. The DON reported she expected the social worker to document a comprehensive assessment with an analysis of findings.	F 636	deficiency. The plan should address the processes that lead to the deficiency cited; The facility failed to conduct comprehensive assessments to identify and analyze how resident condition affected function and quality of life related to behaviors for resident #73. On date 5/10/18, the Minimum Data Set (MDS) Registered Nurse reassessed resident (# 73) to identify and analyze how his condition affected his function and quality of life related to his behavioral issues. On 5/11/18, resident #73□s MDS was corrected via Significant Correction to a Prior Comprehesive MDS Assessment to accurately reflect his behavior problems. The documentation for resident #73 is detailed in the behavioral care area assessment (CAA). The Significant Correction was completed with the Assessment Reference Date (ARD) of 5/10/18 and was accepted to the state data base on 5/17/18 with the submission ID # 14781315. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; On 5/15/18 the Regional Minimum Data Set (MDS) Consultant and facility Care plan team completed 100 % audit of all current residents with a triggered Behavioral CAAs in the last 6 months. Only one other resident was found to have triggered for Behavioral Symptoms and	

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F 636	Continued From page 3	F 636	required a correction completed to accurately reflect her behavioral symptoms. A significant Correction to a Prior Comprehensive (SCPC) was completed with the Assessment Reference Date of 5/15/18 and was accepted to state data base on 5/17/18 with submission ID # 14781315. On 5/9/18, the Regional MDS Consultant completed an in service training for the facility MDS Registered Nurses and Social Services Directors on how to conduct a comprehensive assessment, identifying and analyzing conditions that can affect the function and quality of life of residents with consideration to their cognitive status. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; On 5/17/18, the MDS Coordinator began auditing the Behavior Symptom Care Area Assessment (CAA) using the MDS CAA Monitoring tool to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and in compliance with the regulatory requirements. This will be done weekly for 4 weeks then monthly for 3 months. Reports will be presented to the weekly quality assurance (QA) committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly QOL Meeting is attended by the Administrator,	

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F 636	Continued From page 4	F 636	Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager (HIM), Dietary Manager and the Activity Director. The Administrator and/or Director of Nursing will be responsible for implementing the acceptable plan of correction.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of active diagnoses and restraint application for 3 of 23 sampled residents (Resident #62, Resident #44 and Resident #21). Findings included: 1. Resident #62 was admitted to the facility on 10/6/2016 with diagnoses that included acute kidney failure, type 2 diabetes mellitus, hypertension, dementia and major depressive disorder. Review of the quarterly Minimum Data Set (MDS0, Section I (Active Diagnosis), dated 4/10/2018 revealed that Resident #62 was coded as being moderately impaired as having the following diagnosis: acute kidney failure, type 2 diabetes mellitus, hypertension, atherosclerotic heart disease, Alzheimer's disease, dementia, fitting and adjustment urinary device, dorsalgia,	F 641	F641 Accuracy of Assessment The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of active diagnosis and restraint application for 3 of 23 residents (#62), (#44), and (#21) On 05-03-18, the Minimum Data Set Registered Nurse (MDS) reassessed Resident (# 62). The findings were that Major Depressive disorder was not included in the active diagnosis list. On 05-03-18, a modification to correct was completed with an Attestation Date of 05-03-18 and an acceptance date of	5/18/18

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F 641	Continued From page 5 collapsed vertebra, rhabdomyolysis, COPD, hyperparathyroidism, CHF, benign prostatic hyperplasia, history of falling. Major depressive disorder was not coded as active. Review of the electronic medical record revealed current physician orders with a start date of 3/9/2017 for Remeron 15mg HS for the diagnosis of Depression. Further review of the electronic medical record revealed no end date for these medications. An interview on 5/3/2018 at 3:34 PM with the MDS nurse revealed that active diagnoses were coded by the Medical Records manager. Once the active diagnoses were coded by the Medical Records manager, the information would pull over to the MDS. The MDS nurse revealed that she signed off on Resident #62's assessment but missed the diagnosis. The MDS nurse revealed that Resident #21 was currently being treated for depression. The MDS nurse stated that depression should be listed as an active diagnosis. On 5/3/2018 at 9:41 AM an interview with the Administrator and Director of Nursing revealed that the expectation of the facility was that diagnoses are accurately coded with what the resident were admitted for. They stated we strive for 100% accuracy. 2. Resident #44 was admitted to the facility on 12/18/2015 with diagnoses that included normal pressure hydrocephalus, chronic pan sinusitis, dysphagia, disorientation, hypertension, ataxia, hypokalemia, GERD, history of falls, malignant neoplasm of breast, asthma. Review of the quarterly Minimum Data Set (MDS), Section P	F 641	05-04-18. Submission ID# 14708044. On 05-03-18, the Minimum Data Set Registered Nurse (MDS) reassessed Resident (# 44). The findings were that the resident did not require the use of a restraint. On 05-02-18, a modification to correct was completed with an Attestation Date of or 05-02-18 and an acceptance date of 05-03-18. Submission ID# 14698768. On 05-03-18, the Minimum Data Set Registered Nurse (MDS) reassessed Resident (# 21). The findings were that the resident continued to be treated for PVD and GERD. On 05-03-18, a modification to correct was completed with an Attestation Date of 05-03-18 and an acceptance date of 05-04-18. Submission ID# 14708044. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: On 05-17-18, the Regional Minimum Data Set Consultant (MDS) and facility Minimum Data Set Registered Nurse (MDS) completed 100 % audit of all current resident□s medical record review for active diagnosis and that the active diagnosis is included on the MDS. Twelve residents with current medication for depression did not have a diagnosis of dementia coded in Section I as active. On 05-17-18, all twelve were corrected via modification with an attestation date of 05-17-18 and are awaiting a submission ID#.	

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F 641	Continued From page 6 (Restraints), dated 3/20/2018 revealed that Resident #44 was coded as having restraints. Resident #44's cognition was coded as being moderately impaired. Several observations were done throughout this survey of Resident #44 where Resident #44 was self-propelling in her room, eating in the dining room and participating in activities. There were no signs of restraints being used on Resident #44. On 5/2/2018 at 9:38 AM an interview with the MDS nurse revealed that the MDS should never be coded as using restraints. The further indicated the facility is restraint free and alarm free. She stated the coding was a typographical error. On 5/3/2018 at 9:41 AM an interview with the Administrator and Director of Nursing revealed that the expectation of the facility was that diagnoses are accurately coded with what the resident were admitted for. They stated we strive for 100% accuracy. 3. Resident #21 was admitted to the facility 2/26/2018 with diagnoses that included dementia, hypertension, peripheral vascular disease (PVD) and gastroesophageal reflux disease (GERD). Resident #21 was coded as being cognitively impaired. Review of the admission Minimum Data Set (MDS), Section I (Active Diagnosis), dated 3/5/2018 revealed that Resident #21 was coded as having the following diagnoses: anemia,	F 641	On 05-16-18, the Regional Minimum Data Set Consultant completed an in service training for both of the facility Minimum Data Set Registered Nurses on how to accurately coding of diagnosis of a resident□s MDS for all current residents that reside in the facility. Education information: The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; Starting 05-21-18, the Director of Nursing will audit 5 residents using the MDS Accuracy Tool to ensure accuracy and compliance. The audit will be will be done weekly for 4 weeks then monthly for 3 months. Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager and the Activity Director The Administrator and/or Director of Nursing will be responsible for implementing the acceptable plan of correction.	

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F 641	Continued From page 7	F 641		

hypertension, heart failure, atrial-fibrillation, non-Alzheimer's dementia, depression, chronic obstructive pulmonary disease, and macular degeneration. PVD and GERD were coded as not active.

Review of the electronic medical record revealed current physician orders with a start date of 2/27/2018 for Pantoprazole Sodium Tablet Delayed Release 20 MG for the diagnosis of GERD and Cilostazol Tablet 100 MG for the diagnosis of PVD. Further review of the electronic medical record revealed no end date for these medications.

An interview on 5/3/2018 at 8:02 AM with the Nurse Practitioner (NP) revealed that Resident #21 continued to be treated for GERD and PVD. The NP indicated that the diagnoses were current and active.

An interview on 5/3/2018 at 8:46 AM with the MDS nurse revealed that active diagnoses were coded by the Medical Records manager. Once the active diagnoses were coded by the Medical Records manager, the information would pull over to the MDS. If a new diagnosis were added or a diagnosis were no longer current, then a diagnosis request form would be completed by nursing for the Medical Records manager to update. The MDS nurse revealed that she coded based on the review of current medications. The MDS nurse revealed that Resident #21 was currently being treated for GERD and PVD. The MDS nurse revealed that GERD and PVD should be listed as an active diagnosis.

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F 641	Continued From page 8 An interview on 5/3/2018 at 9:10 AM was conducted with the Medical Records manager. She revealed that she utilized the following forms to capture a resident's active diagnoses: the discharge summary, the history and physical, and the admission orders. If new diagnoses were added, then a diagnoses request form would be completed, that indicated where they obtained the information before a new diagnoses was added. On 5/3/18 at 9:21 AM an interview with the Administrator and Director of Nursing revealed that the expectation of the facility was that diagnoses are accurately coded with what the resident were admitted for or if a diagnosis were added. The facility does have a Regional Nurse Consultant who completes, on a percentage basis, review of all MDS' for accuracy.	F 641		
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	F 656		5/18/18

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F 656	Continued From page 9 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 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 observations, staff interviews and record review, the facility failed to develop a resident centered comprehensive care plan related to activity needs for 1 of 4 sampled residents with cognitive deficits (Resident #73). The findings included: Resident #73 was admitted to the facility on 11/03/17 with diagnoses which included dementia.	F 656	F656 Develop /Implement Comprehensive Care Plan The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The facility failed to develop a resident centered comprehensive care plan related to activity needs for resident # 73	

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F 656	Continued From page 10 Review of Resident #73's admission Minimum Data Set (MDS) dated 11/10/17 revealed an assessment of intact cognition with verbal behaviors directed toward others. The MDS indicated reading material access, listening to music, and the ability to go outside when the weather is good were very important to Resident #73. Resident #73 indicated it was somewhat important to keep up with the news and be with groups of people during the MDS interview. The MDS did not trigger the Activity Care Area Assessment. Review of Resident #73's quarterly MDS dated 01/19/18 revealed an assessment of moderately impaired cognition with no behaviors and use of a daily antipsychotic medication. Review of Resident #73's quarterly MDS dated 04/17/18 revealed an assessment of moderately impaired cognition with no behaviors and used of a daily antipsychotic medication. Review of Resident #73's care plan revised 03/26/18 revealed interventions listed for care resistance were to remain in bed when agitated, praise appropriate behavior and provide opportunities for choice during care. There were no interventions regarding an activity program on the care plan. Observation on 04/30/18 at 11;13 AM and 11:29 AM revealed Resident #73 awake and in bed. Resident #73 shouted out a desire to return to a ranch. Observation on 04/30/18 at 12:41 PM revealed Resident #73 ate independently in bed. The	F 656	On 5/3/18 the MDS Registered Nurse and the Activity Director reassessed Resident #73 in order to determine care plan needs. Resident # 73 did not have a comprehensive care plan. On 5/3/18, the MDS Registered Nurse and Activity director completed and implemented a comprehensive resident centered care plan for Resident #73. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: On 5/9/18, the Regional MDS Consultant, the facility MDS Registered Nurse and Activity Director completed 100 % audit of all current residents comprehensive assessments for appropriate activity care plans. 32 of 68 residents were found without comprehensive Activity care plans. On 05-17-18, the Activity Director developed a comprehensive Activity care plan for each of the residents according to their interests and cognitive status. On 5/9/18, the Regional MDS Consultant completed an in service training for the two facility MDS Registered Nurses, the Social Services Directors and Activity Director on how to assess and develop a resident centered comprehensive activity care plan with consideration to the residents' cognitive status. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected	

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F 656	Continued From page 11 television was programmed to a situation comedy. Observation on 04/30/18 at 3:46 PM revealed Resident #73 awake and alert. Resident #73 was in bed with a situation comedy on the television. Resident #73 shouted a desire leave and smoke a pipe. Observation on 05/01/18 at 3:38 PM revealed Resident #73 awake and in bed. Resident #73 pointed to the sky and talked to the ceiling. Observations on 05/02/18 at 9:01 AM, 9:45 AM, 11:20 AM and 12:34 PM revealed Resident #73 asleep in bed. Interview with Nurse Aide (NA) #1 on 05/02/18 at 12:17 PM revealed Resident #73 remained in his bed during the day. NA #1 explained he did not know what activities Resident #73 enjoyed. Interview with NA #2 on 05/02/18 at 3:18 PM revealed Resident #73 became verbally aggressive when out of the bed and out of the room. Interview with Nurse #1 on 05/02/18 at 3:22 PM revealed Resident #73 remained in bed during the day. Nurse #1 explained Resident #73 became agitated when out of the room. Interview with the activity director on 05/03/18 at 8:44 AM revealed she became employed as the activity director several weeks ago. The activity director reported Resident #73's care plan should include activity interventions for cognition and behaviors.	F 656	and/or in compliance with the regulatory requirements; Starting 05-21-18, the Director of Nursing and/or the Activity Director will audit 5 comprehensive MDS Assessments using the Activity Assessment and Care Plan tool to ensure that a comprehensive care plan is developed for all residents. This will be done weekly for 4 weeks then monthly for 3 months. Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager and the Activity Director The Administrator and/or Director of Nursing will be responsible for implementing the acceptable plan of correction.	

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	345563	A. BUILDING _____ B. WING _____	C 05/03/2018

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F 656	Continued From page 12 Interview with the Director of Nursing (DON) on 05/03/18 at 9:41 AM revealed Resident #73's care plan should contain activity interventions.	F 656		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to provide an ongoing activity program which met the individual interest and needs to enhance the quality of life for 1 of 4 sampled residents with cognitive deficits (Resident #73). The findings included: Resident #73 was admitted to the facility on 11/03/17 with diagnoses which included dementia. Review of Resident #73's admission Minimum Data Set (MDS) dated 11/10/17 revealed an assessment of intact cognition with verbal behaviors directed toward others. The MDS indicated reading material access, listening to music, and the ability to go outside when the	F 679	F679 Activities Meet Interest/needs of Each Resident The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The facility failed to provide an ongoing activity program which met the individual interest and needs to enhance the quality of life for residents with cognitive deficits for 1 of 4 sampled residents, resdient (#73) On 05-02-18, the MDS Registered Nurse and Activity Director reassessed Resident (# 73) in order to determine an appropriate individualized activity	5/18/18

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F 679	Continued From page 13 weather is good were very important to Resident #73. Resident #73 indicated it was somewhat important to keep up with the news and be with groups of people during the MDS interview. The MDS did not trigger the Activity Care Area Assessment. Review of Resident #73's quarterly MDS dated 01/19/18 revealed an assessment of moderately impaired cognition with no behaviors and use of a daily antipsychotic medication. Review of an activity review dated 01/19/18 revealed Resident #73 is was important to go outside in good weather, participate in religious services, have reading material and keep up with the news. The activity review indicated music was not important to Resident #73. Review of Resident #73's quarterly MDS dated 04/17/18 revealed an assessment of moderately impaired cognition with no behaviors and used of a daily antipsychotic medication. Observation on 04/30/18 at 11;13 AM and 11:29 AM revealed Resident #73 awake and in bed. Resident #73 shouted out a desire to return to a ranch. Observation on 04/30/18 at 12:41 PM revealed Resident #73 ate independently in bed. The television was programmed to a situation comedy. Observation on 04/30/18 at 3:46 PM revealed Resident #73 awake and alert. Resident #73 was in bed with a situation comedy on the television. Resident #73 shouted a desire leave and smoke a pipe.	F 679	program. On 05-03-18, the Activity director implemented a resident centered comprehensive activity program to address cognitive deficits and to include non-pharmacologic approaches to address behavioral issues. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: On 05-16-18, the Regional MDS Consultant, the facility Administrator and Activity Director completed a 100 % audit of residents with a diagnosis of dementia. Four residents with dementia needed a comprehensive activity program. On 05-10-18, the Regional MDS Consultant completed an in-service training for the facility Activity director on how to develop an ongoing activity program the meets the individual interest and needs and enhance the quality of life of all residents. On 05-17-18, the Regional MDS Consultant and Quality Assurance Nurse Consultant further in-serviced the Activity Director on the Activity Policy ACP#101. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Administrator and/or Director of	

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F 679	Continued From page 14 Observation on 05/01/18 at 3:38 PM revealed Resident #73 awake and in bed. Resident #73 pointed to the sky and talked to the ceiling. Observations on 05/02/18 at 9:01 AM, 9:45 AM, 11:20 AM and 12:34 PM revealed Resident #73 asleep in bed. Interview with Nurse Aide (NA) #1 on 05/02/18 at 12:17 PM revealed Resident #73 remained in his bed during the day. NA #1 explained he did not know what activities Resident #73 enjoyed. Interview with NA #2 on 05/02/18 at 3:18 PM revealed Resident #73 became verbally aggressive when out of the bed and out of the room. Interview with Nurse #1 on 05/02/18 at 3:22 PM revealed Resident #73 remained in bed during the day. Nurse #1 explained Resident #73 became agitated when out of the room. Interview with the activity director on 05/03/18 at 8:44 AM revealed she became employed as the activity director several weeks ago. The activity director explained she had not had the opportunity to meet Resident #73. The activity director was not able to provide information regarding Resident #73's activity interventions and participation since admission on 11/03/17. Interview with Nurse #2 on 05/03/18 at 9:09 AM revealed Resident #73 became agitated when out of the room. Nurse #2 reported Resident #73's agitation increased when around others. Interview with the nurse practitioner on 05/03/18	F 679	Nursing will audit 5 resident charts using the Activity Assessment and Care Plan Audit tool to ensure that all residents have completed, comprehensive, resident-centered Care Plans. This audit will be done weekly for 4 weeks; then monthly for 3 months. Reports will be presented to the weekly QOL committee by the Administrator and/or Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager and the Activity Director. The Administrator and/or Director of Nursing will be responsible for implementing the acceptable plan of correction.	

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F 679	Continued From page 15 at 9:21 AM revealed Resident #73 required staff interventions which included an activity program for dementia. Interview with the Director of Nursing (DON) on 05/03/18 at 9:41 AM revealed Resident #73's nonpharmacologic approaches for behavior problems should include an activity program.	F 679		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review the facility failed to honor food preferences for 1 of 6 residents reviewed for preferences (Resident #339). Findings included: Resident #339 was admitted to the facility on 4/18/2018. The admission Minimum Data Set (MDS) indicated that Resident #339 was cognitively intact. The MDS also indicated Resident #339 was edentulous (without teeth) and on a therapeutic diet (cardiac diet).	F 806	F806 Resident allergies, Preferences, Substitutions The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The facility failed to honor the food choice of 1 of 6 resident (Resident # 339) who preferred sliced turkey for breakfast. The Facility has promoted and facilitated resident food preferences through support of resident food choices and providing	5/18/18

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F 806	Continued From page 16 Review of the care plan dated 4/19/2018 revealed that Resident #339 had a problem/ need of nutrition related to receiving therapeutic diet. The goal identified for Resident #339 revealed that she will maintain adequate nutritional status. The interventions included that Resident #339 would receive an evaluation from the Registered Dietician and make changes/ recommendations, the facility would explain/ reinforce the importance of maintaining the diet as ordered. Review of the electronic medical record revealed a Dietician note dated 4/19/2018 that revealed Resident #339's preferences were obtained, nutritional assessment to follow. Review of the dietician's nutritional assessment dated 4/19/2018 revealed that no preferences were obtained. Review of the resident food preference form, no date, revealed that Resident #339 disliked oatmeal and had no food allergies or intolerances. During an interview on 4/30/2018 at 1:10 PM Resident #339 verbalized that she was not getting her sliced turkey at breakfast. Resident #339 indicated that this has happened for several days since she was admitted to the facility. During an observation and interview on 5/1/2018 at 8:45 AM Resident #339 received a cheese omelet, grits, cereal, milk, orange juice and coffee. Resident #339 did not receive her sliced turkey. Review of the meal ticket dated, Tuesday	F 806	food those foods as requested. On 05-02-18, the dietary manger interviewed resident (#339) and obtained food preferences, in writing, using the Food Preferences form. On 05-17-18, the Quality Assurance nurse consultant and Dietary Manager completed a review of the past 30 days' admission for completion of food preferences. On 05-17-18, the Dietary Manager completed food preferences for 5 residents newly admitted. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; On 05-10-18, the Regional MDS Registered Nurse in-serviced the facility Dietary Manager on obtaining residents dietary preferences to ensure residents honored food choices were provided. On 05-14-18, the Dietitian began in-serving the Dietary Manager and Dietary Department on adhering to residents food choices at every meal. As of 05-21-18, no dietary department employee will be allowed to work until the training has been completed. Effective 05-21-18, this training is incorporated into the new employee orientation program. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.	

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F 806	Continued From page 17 5-1-18, revealed that Resident #339 was a cardiac diet and received thin liquids. Tray notes revealed that resident should receive turkey at breakfast meal. During an observation and interview on 5/2/2018 at 8:36 AM Resident #339 had to send her breakfast tray back to the kitchen due to bacon being served. Resident #339 did not have sliced turkey on her tray as indicated on her meal ticket. Resident #339 received grits, French toast, cereal, milk, orange juice and coffee. The nurse aide went back to dietary to get preferred breakfast item (turkey). Review of the dietary review dated 5/2/2018 revealed that no food preferences were obtained. An interview was conducted on 5/3/2018 at 8:24 AM with the Dietary Manager (DM) and the Chef Manager (CM) that revealed the DM was responsible for capturing likes and dislikes. When the facility received a new admission, the DM would complete a Resident Food Preference Form. The DM reviewed this form with the resident and obtained likes and dislikes. The DM also indicated that when a resident was due for a MDS (quarterly/ significant change/ annual assessment), she updated the Resident Food Preference form. The DM verbalized that her expectations were that employees were reading the tray tickets to ensure resident food preferences were honored. An interview was conducted on 5/3/2018 at 9:37	F 806	The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; Starting 05-21-18, the Dietary Department Manager will interview 5 alert and oriented residents using the Food Preference Compliance tool to ensure that the facility is promoting and facilitating residents honored food choice for those residents who expressed food preferences. Additionally beginning 05-21-18, the Food Service Manager will complete a food tray audit of 5 resident meals, which will compare the tray ticket with the actual food provided on the tray, using the QA Tray Accuracy Tool. These audits will be done weekly for 4 weeks; then monthly for 3 months. Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly QA Meeting is attended by the Director of Nursing, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator The Administrator and/or Director of Nursing will be responsible for implementing the acceptable plan of correction.	

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F 806	Continued From page 18 AM with the Administrator and DON that revealed the facility would honor the resident's preferences, as long as, the preference did not conflict with the prescribed diet ordered.	F 806		