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	345499	A. BUILDING _____ B. WING _____	C 05/10/2018

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LITCHFORD FALLS HEALTHCARE	8200 LITCHFORD ROAD RALEIGH, NC 27615

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F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		6/6/18

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

Electronically Signed | 06/04/2018

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F 550	Continued From page 1 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to maintain residents ' dignity by standing over 2 of 4 residents while providing assistance with feeding (Resident #54 and Resident #53). The findings included: 1) Resident #54 was admitted to the facility on 10/9/13 from another nursing home or swing bed. Her cumulative diagnoses included dementia and malnutrition. A review of Resident #54 ' s quarterly MDS (Minimum Data Set) assessment dated 4/3/18 revealed the resident had severely impaired cognitive skills for daily decision making. The resident required extensive assistance from staff for bed mobility, transfers, eating and toileting. She was totally dependent on staff for locomotion on and off the unit, dressing, and personal hygiene. Section K of the MDS revealed Resident #54 received a therapeutic, mechanically-altered diet. A review of Resident #54 ' s care plan (revised on 4/19/18) included an area of focus related to nutrition. The interventions included, "fed by staff." On 5/7/18 at 12:40 PM, Resident #54 was observed to be lying in bed with the head of the bed raised. A lunch tray was placed on the bedside table in front of the resident. On 5/7/18 at 12:56 PM, Nursing Assistant (NA) #1 was	F 550	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. F550 ROOT CAUSE This alleged noncompliance was resulted from the Nursing Assistant #1 (NA) standing on left side of bed to assist resident #54 and resident #53 with feeding on 05/07/2018 and 05/08/2018 respectively. The action by the NA #1 was not in alignment with the facility efforts that promote resident independence and dignity while dining. This was also caused by the facility failure to include dignity training during dining for nursing staff upon hire, and routinely afterwards to ensure proper knowledge of the facility rationale for expecting employees to sit while assisting residents with meals. IMMEDIATE ACTION	

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F 550	Continued From page 2 observed as she entered Resident #54 ' s room and assisted her with the meal. NA #1 stood on the left side of the bed as she fed Resident #54. A chair was observed to be available in the room and was located on the right side of the bed. On 5/7/18 at 12:58 PM, NA #1 was observed as she brought Resident #54 ' s meal tray out of the resident ' s room and put it on the dirty tray cart. A second observation was conducted on 5/8/18 at 12:47 PM as NA #1 stood on the left side of Resident #54 ' s bed. Resident #54 was lying in her bed with the head of the bed raised while NA #1 fed the resident her meal. The NA was standing over the resident. She was not overheard to be conversing with the resident. A chair was observed to be available in the room. A follow-up observation conducted on 5/8/18 at 12:58 PM revealed the NA was still standing over Resident #54 as she was feeding her. On 5/8/18 at 12:59 PM, NA #1 brought Resident #54 ' s meal tray out of the room and placed it on the dirty tray cart. An interview was conducted on 5/9/18 at 10:35 AM with NA #1 to discuss the observations made as she was assisting residents with their meals. During the interview, NA #1 stated, "It ' s a bad habit of mine to stand." When asked, the NA reported the facility preferred she sit down when feeding a resident. An interview was conducted on 5/10/18 at 10:00 AM with the facility ' s Administrator. Upon discussion of the observations made of staff standing while feeding residents, the Administrator was asked what her expectations were. The Administrator stated, "That they sit."	F 550	On 05/10/2018, Nursing Assistant #1 was re-educated by the facility Staff Development Coordinator on the importance of seating while assisting resident with meals to promote each resident's dignity. NA#1 voiced understanding of this expectation. On 05/31/2018 Resident #54 was observed being provided assistance with feeding with the Nursing Assistant #1 while sitting at bedside by the Assistant Director of Nursing. On 05/31/2018 Resident #53 was observed being provided assistance with feeding with the Nursing Assistant #1 while sitting at bedside by the Assistant Director of Nursing. IDENTIFICATION OF OTHERS All residents who need assistance during meals have the potential to be affected by this alleged deficient practice. On 06/01/2018, the Director of Nursing, Assistant Director of Nursing and/or Staff Development Coordinator completed 100% audit of current residents in the facility that need assistance with feeding to ensure nursing assistants and/or nurses were sitting when providing assistance. No other staff member was noted standing while assisting resident with meals. Findings of this audit is documented on the 'Dining Dignity Audit Tool', maintained in the facility's compliance binder.	

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F 550	Continued From page 3 An interview was conducted on 5/10/18 at 10:34 AM with the facility ' s Director of Nursing (DON). During the interview, the observations of nursing staff standing while feeding residents were discussed. The DON stated, "That is not acceptable and that is not what we do." The DON added this was a dignity issue and reported staff re-education was being initiated. 2) Resident #53 was admitted to the facility on 4/20/09 with reentry on 9/9/17 after a hospital admission. Her cumulative diagnoses included dementia. A review of Resident #53 ' s quarterly MDS (Minimum Data Set) assessment dated 4/3/18 revealed the resident had severely impaired cognitive skills for daily decision making. The MDS indicated Resident #53 required extensive assistance from staff for eating and toileting; she was totally dependent on staff for dressing and personal hygiene. Section K of the MDS revealed Resident #53 received a therapeutic, mechanically-altered diet. A review of Resident #53 ' s care plan (revised on 4/3/18) included an area of focus related to nutrition. The interventions included, "fed by staff." An observation was conducted on 5/7/18 at 12:50 PM as NA #1 stood next to Resident #53 ' s bed. The resident was lying in her bed with the head of the bed raised while the NA fed her. A follow-up observation conducted on 5/7/18 at 12:54 PM revealed the NA was still standing over the resident (above eye level) as she was feeding her. She was not overheard to be conversing with the resident. A chair was observed to be	F 550	SYSTEMIC CHANGES Effective 6/6/2018, and moving forward, nursing staff will sit and not stand while providing assistance with meals for all residents who requires assistance with feeding. Starting 05/10/2018, the Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinators will complete 100% education for all current nursing staff, to include full time, part time and as needed employees on being seated when assisting a resident with their meals. The education will put an emphasis on the importance of maintaining residents' dignity during dining by always sit while assisting residents with meals. This education will be completed by 06/06/2018, any nursing staff not educated by 06/06/2018 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new nursing employees effective 06/06/2018. MONITORING PROCESS Effective 06/06/2018, the Executive Director, Director of Nursing, Assistant Director of Nursing and/or Staff Development Coordinator will make rounds during breakfast, lunch and/or dinner to observe residents being assisted with meals and ensure nursing assistants and/or nurses are maintaining resident dignity by being seated while assisting with their meal. Findings from this monitoring process will be documented on	

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F 550	Continued From page 4 available in the room. An interview was conducted on 5/9/18 at 10:35 AM with NA #1 to discuss the observations made as she was assisting residents with their meals. During the interview, NA #1 stated, "It ' s a bad habit of mine to stand." When asked, the NA reported the facility preferred she sit down when feeding a resident. An interview was conducted on 5/10/18 at 10:00 AM with the facility ' s Administrator. Upon discussion of the observations made of staff standing while feeding residents, the Administrator was asked what her expectations were. The Administrator stated, "That they sit." An interview was conducted on 5/10/18 at 10:34 AM with the facility ' s Director of Nursing (DON). During the interview, the observations of nursing staff standing while feeding residents were discussed. The DON stated, "That is not acceptable and that is not what we do." The DON added this was a dignity issue and reported staff re-education was being initiated.	F 550	a 'Dining with Dignity Monitoring form' maintained in the facility compliance binder. This monitoring process will take place for one meal daily (Monday through Friday) for 2 weeks then 3x/week for two more weeks, then weekly for 2 weeks then monthly for 3 months or until the pattern of compliance is maintained. Effective 06/06/2018, the Week end supervisor or designated Manager on duty will make rounds during breakfast, lunch and/or dinner to observe residents being assisted with meals and ensure nursing assistants and/or nurses are maintaining resident dignity by being seated while assisting with their meal. Findings from this monitoring process will be documented on a 'Dining with Dignity Monitoring form' maintained in the facility compliance binder. This monitoring process will take place for one meal on Saturdays & Sundays for four weekends then one week end a month for 3 months or until the pattern of compliance is maintained. Effective 06/06/2018, the Executive Director, Director of Nursing, Assistant Director of Nursing and/or Staff Development Coordinator will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility	

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F 550	Continued From page 5	F 550	remains in substantial compliance. RESPONSIBLE PARTY Effective 06/06/2018, the center Executive Director and the Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance. Compliance date 6/6/2018	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		6/6/18

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F 584	Continued From page 6 §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 staff interviews and observation the facility failed to (1) maintain resident rooms in good repair, doors free of holes and jagged splintered edges and resident equipment clean. (Rooms #116,115, 125, 129, 207, 218, 221, 302,303, 307, shower room and 100-200 unit nourishment room) (2). maintain clean and intact walls (Rooms # 118, 119, 123, 218, 221, and 307,) and (3) maintain clean floors (Rooms # 307,221 and 119). This was evident in 3 of 3 resident care units. Findings included: 1.a. Observation on 05/07/18 at 11:53 AM in Room 116 revealed the front panel of the heating and air-conditioning unit was partially detached from the unit. b. Observation on 05/07/18 at 12:12 PM in Room #129B revealed the bedside cabinet had partially missing veneer on the side of the cabinet.	F 584	F584 ROOT CAUSE This alleged noncompliance was resulted from the facility staff failed to communicate housekeeping, laundry and maintenance needs in the facility. This was also resulted from facility failure to have a functional systemic process of communicating maintenance needs. The root cause analysis conducted by the facility Executive Director further reveal that, this alleged noncompliance was also resulted from unclear expectation of daily duties to be performed by each housekeeping staff. IMMEDIATE ACTION TAKEN 1a. on 05/29/2018, Room #116 front panel	

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F 584	Continued From page 7 c. Observation on 5/07/18 at 12:31 PM in Room 307 revealed the tube feeding (TF) pole had dried tan spots resembling TF formula. d. Observation on 05/08/18 at 08:53 AM in Room 221A revealed the over- bed table legs and base were soiled. e. Observation on 5/8/18 at 10:15 AM in Room 307 revealed the TF pole had streaks of dried brown colored substance on it. f. Observation on 05/08/18 at 11:22 AM in Room 115 revealed a hole in the bathroom door. g. Observation on 05/09/18 at 8:30 AM in room 125 revealed a gray colored duck tape on the side of the cabinet. The overbed table had chipped veneer with black tape applied. The blue mat on the floor was soiled with dried substance and 3 pieces of paper were stuck on the back portion of the mat. h. Observation on 05/09/18 at 8:47 PM revealed in Room #303 the filter for the heating and air-conditioning unit was not secured in the unit. i. Observation on 05/09/18 at 8:35 AM In the shower room located on the 100 and 300 Unit revealed 1 (1) of the 2 (two) light bulbs were functioning. On 5/9/18 at 8:45 AM the bathroom lights in Room 302 were flickering. j. Observation on 05/09/18 at 09:25 AM in Room 211A revealed the over bed table legs were soiled with dried food debris. k. Observation in 05/09/18 at 09:25 AM in bathroom 303 revealed the door frame was chipped. l. Observations on 05/10/18 at 12:40 PM in room207 with the administrator revealed there was a hole in the door and splintered. m. Observation on 5/9/18 at 1:20 PM revealed in Room 116 the front panel of the heating and air conditioning unit continued to be partially detached.	F 584	of the heating and air-conditioning unit was reattached to the unit by the facility Maintenance Director. 1b. on 06/01/2018, the bedside cabinet in Room #129B was removed from resident use by the facility Maintenance Director. 1c. on 06/01/2018, the tube feeding pole with dried tan spots resembling tube feed in room #307 was cleaned by the Housekeeping Supervisor. 1d. on 06/01/2018, the over-bed table legs and base in Room #221A was cleaned by the Housekeeping Supervisor. 1e. on 06/01/2018, the tube feeding pole with dried brown colored substance in room #307 was cleaned by the Housekeeping Supervisor. 1f. on 06/02/2018, the hole in the bathroom door in Room #115 was repaired by the facility Maintenance Director. 1g. on 06/02/2018, the gray colored duct tape in Room #125 was removed by the facility Maintenance Director. On 06/01/2018, the over bed table with chipped veneer in Room #125 was removed from service and replaced with new one. On 06/02/2018, the blue mat with dried substance and 3 pieces of paper stuck to the back portion of the mat in Room #125 was cleaned by the Housekeeping Supervisor.	

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F 584	Continued From page 8 n. Observation on 05/08/18 at 04:36 PM in the 100/200 Unit nourishment room revealed the drain in the sink had an accumulation of leaves. The inside upper portion of the microwave had an accumulation of dried food debris. 2. a. Observation on 05/07/18 at 11:51 AM in Room 218-A revealed the wall behind the bed was scratched and marred. There was a dried brown colored substance on the wall. b. Observation on 5/07/18 at 12:31 PM in Room 307 revealed the wall had streaks of tan/brown colored substance. c. Observation on 05/08/18 at 08:27 AM revealed multiple red colored dried splatter on the wall next to 123 b bed. d. Observation on 05/08/18 at 8:53 AM in Room 221A revealed wall damage around bathroom door. e. Observation on 05/08/18 at 09:38 AM in Room 117 revealed dirty and stained walls. f. Observation on 5/8/18 at 10:15 AM in Room 307 revealed the wall continued to have dried tan/brown colored streaks. g. Observation on 05/08/18 at 11:22 AM in Room #115 revealed the walls had dried brown colored splatter. h. Observation on 05/08/18 at 11:30 AM in Room 113B revealed the walls were dirty. i. Observation on 05/08/18 at 12:28 PM in Room 119 revealed soiled walls. j. Observation on 05/08/18 at 01:37 PM in Room 118B revealed the wall was in disrepair. k. Observation in the 100 and 200-unit nourishment room on 05/08/18 at 04:36 PM revealed the cove molding had partially separated from the wall. l.. Observation on 05/09/18 at 8:20 AM in room	F 584	1h. On 05/29/2018, Room# 303 front panel of the heating and air-conditioning unit was reattached to the unit by the facility Maintenance Director. 1i. On 05/29/2018, the lights in the shower room located on the 100 and 300 hall light bulbs were replaced by the facility Maintenance Director. On 06/01/2018, the bathroom lights in Room #302 were replaced by the facility Maintenance Director. 1j. On 06/01/2018, the over-bed table legs and base in Room #211A was replaced with a new over bed table by the facility Maintenance Director. 1k. On 06/01/2018, the bathroom door frame was repaired and repainted in Room #303 by the facility Maintenance Director. 1l. on 06/02/2018, the hole in the door in Room #207 was repaired by the facility Maintenance Director. 1m. on 05/29/2018, Room# 116 front panel of the heating and air-conditioning unit was reattached to the unit by the facility Maintenance Director. 1n. on 05/31/2018, the 100/200 unit nourishment room drain in the sink was cleaned out by the Housekeeping Supervisor. On 05/31/2018, the inside portion of the microwave with accumulation of dried food debris was cleaned by Housekeeping Supervisor.	

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F 584	Continued From page 9 1118 revealed the wall had several black and brown colored soiled areas. The windowsill had peeling paint. There was a brown spot in the ceiling. m. Observation on 05/09/18 at 8:30 AM in room 125 revealed an accumulation of brown colored substance in the corners of the floor. The blue mat on the floor was soiled with a dried substance with 3 pieces of paper stuck on the back portion of the mat n. Observations on 05/10/18 12:40 PM with the administrator revealed in room207 there was This room had been recently painted and the walls had black marking along the right side of the resident's bed. In room 105 the floor tiles had brown colored stains 3. a. Observation on 5/07/18 at 12:31 PM revealed the floor tiles in Room 307A had multiple (4) dried tan nickel-size spots which resembled tube feeing formula. b. Observation on 05/08/18 at 08:48 AM in Room 209 revealed dirty floor tiles with dark stains. c. Observations on 05/08/18 at 08:53 AM in Room 221A revealed floor tiles soiled with black marks and stains. There were food spills on floor. d. Observation on 5/8/18 at 10:15 AM revealed floor tiles in Room 307 continued to have multiple (4) dried tan nickel-size spots. e. Observation on 05/08/18 at 12:28 PM revealed soiled floor tiles in Room 119. f. Observations with the administrator on 05/10/18 at 12:40 PM in Room 105 revealed floor tiles had brown colored stains. g. Observation of the 100 and 200-unit nourishment room on 05/08/18 04:36 PM revealed the corners of the floor had a buildup of a black colored substance.	F 584	2a. on 06/04/2018, the wall behind the bed that was scratched and marred in Room #218A was repaired and repainted by the facility Maintenance Director. On 05/31/2018, the dried brown colored substance on the wall in Room #218A was cleaned by the Housekeeping Supervisor. 2b. on 06/02/2018, the wall with streaks of tan/brown colored substance in Room #307 was cleaned by the Housekeeping Supervisor. 2c. on 05/31/2018, multiple red colored dried splatter on the wall in Room #123B bed was cleaned by the Housekeeping Supervisor. 2d. on 06/04/2018, the wall damage around the bathroom door in Room #221A was repaired and repainted by the facility Maintenance Director. 2e. on 05/31/2018, the dirty and stained walls in Room #117 were cleaned by the Housekeeping Supervisor. 2f. on 06/02/2018, the dried tan/brown colored streaks on walls in Room #307 were cleaned by the Housekeeping Supervisor. 2g. on 06/01/2018, the dried brown colored splatter on the wall in Room #115 was cleaned by the Housekeeping Supervisor. 2h. on 06/01/2018, the dirty walls in Room	

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F 584	Continued From page 10 4. a. Observation on 05/07/18 at 11:51 AM in Room 218B revealed the white colored windowsill had an accumulation of dust, a dark colored area and food particles. The shelving in the room had an accumulation of dust. Observations on 05/09/18 beginning at 2 PM revealed the above room conditions noted on 5/7/18, 5/8/18 and 5/9/18 remained. Interview on 05/09/18 at 02:47 PM with House keeper (HK) #1 indicated she was responsible for cleaning windows, bathrooms, floor and overbed tables. When she worked on 100 unit she would clean the tables and remove trash. Before the interview was completed HK #1 stated she was unsure of her responsible and needed to contact her manager. Interview on 05/09/18 at 02:55 PM with the Housekeeping Manager revealed she expected the HK responsible for the assigned hall be clean. During the interview the Housekeeping Manager indicated no one brought to her attention about the status of the soiled walls or floors. Interview on 5/10/18 at 10:30 AM with HK#2 revealed she had rotating unit assignments and duties were to mop and clean the floors, tables, bathrooms and walls. HK #2 indicated the HK staff had a meeting this morning (referring to 5/9/18) and we were instructed to clean the walls. Interview on 5/10/18 at 11:45 AM with the Director of Maintenance (DOM) revealed he had painted all of the resident rooms in 2017. The DOM indicated he was planning to repaint 5 resident rooms a month but had no written plan to address	F 584	#113B were cleaned by the Housekeeping Supervisor. 2i. on 06/01/2018, the soiled walls in Room #119 were cleaned by the Housekeeping Supervisor. 2j. on 06/02/2018, the dis-repaired wall in Room #118B was repaired by the facility Maintenance Director. 2k. on 06/01/2018, the cove molding in the 100 and 200-unit nourishment room was repaired by the facility Maintenance Director. 2l. on 05/31/2018, the several black and brown colored soiled areas in Room #118 was cleaned by the Housekeeping Supervisor. On 05/31/2018, the window sill with peeling paint in Room #118 was repaired by the Facility Maintenance Director. On 06/04/2018, the brown spot on the ceiling in Room #118 was painted by the Facility Maintenance Director. 2m. on 06/02/2018, the accumulation of brown colored substance in the corners on the floor in Room #125 was cleaned by the Housekeeping Supervisor. On 06/02/2018, the blue mat with dried substance and 3 pieces of paper stuck to the back portion of the mat in Room #125 was cleaned by the Housekeeping Supervisor. 2n. on 06/01/2018, the markings alongside the right side of bed on the wall in Room #207 were repaired by the	

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F 584	Continued From page 11 and met his goal. Continued interview revealed he was the only person in maintenance, checked the lighting each day, made repairs as much as he could and depended on a maintenance request form for repairs. Interview on 05/10/18 at 1 PM with the Administrator revealed all resident rooms had been painted in June/July 2017. In April 2018 we started painting Rooms #105, #107, #108, #207, #300 and #304. The Administrator revealed there was no written action plan to paint nor address the soiled and marked walls. Continued interview revealed she expected housekeeping and maintenance services to have rooms clean and in good repair.	F 584	Facility Maintenance Director. On 05/31/2018, the brown colored stains in Room #105 were cleaned by the Housekeeping Supervisor. 3a. on 06/01/2018, the floor tiles with multiple dried tan nickel-size spots which resembled tube feeding formula in Room #307A was cleaned by the Housekeeping Supervisor. 3b. on 06/01/2018, the dirty floor tiles with dark stains in Room #209 were cleaned by the Housekeeping Supervisor. 3c. on 05/31/2018, the floor tiles soiled with black marks and stains and food spills on the floor in Room #221A were cleaned by the Housekeeping Supervisor. 3d. on 06/02/2018, the floor tiles with multiple dried tan nickel-size spots which resembled tube feeding formula in Room #307 was cleaned by the Housekeeping Supervisor. 3e. on 06/01/2018, the soiled tiles in Room #119 were cleaned by the Housekeeping Supervisor. 3f. on 05/31/2018, the brown colored stains in Room #105 were cleaned by the Housekeeping Supervisor. 3g. on 05/31/2018, the corners of the floors with buildup of black colored substance in nourishment room on 100 and 200-unit was cleaned by the	

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F 584	Continued From page 12	F 584	Housekeeping Supervisor. 4a. on 05/31/2018, the white colored window sill with accumulation of dust, a dark colored area and food particles in Room #218B was cleaned by the Housekeeping Supervisor. On 05/31/2018, the accumulation of dust on the shelving in Room #218B was cleaned by the Housekeeping Supervisor. IDENTIFICATION OF OTHERS 100% audits of all resident rooms, and residents' used common areas in the facility conducted by the Maintenance supervisor on 05/10/2018, 05/18/2018, 05/21/2018, and 05/22/2018 to identify any other resident room with the following areas of concerns; resident rooms that are not in good repair, doors with holes, chipped and/or jagged edges, walls with holes, detached panel, or air filters from air conditioning unit, furniture not in good repair, and/or lights that are not functioning. Findings of this audit is documented on "Weekly Enviro-Rounds tool" located in the facility compliance binder. Correction of identified items will be rectified by the Maintenance Director by 06/06/2018. The facility contracted with a maintenance and repair vendor to rectify all areas identified, the maintenance and repair vendor started facility wide repair on 6/1/2018 and will be completed by 6/6/2018.Any resident area identified with concerns and not rectified by 06/06/2018 will be removed from resident care usage until rectified.	

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F 584	Continued From page 13	F 584		

100% audits of all resident rooms in the facility conducted by the Housekeeping Supervisor on 05/22/2018, 05/24/2018 and 05/28/2018 to identify any other resident room with the following areas of concerns; dirty equipment used by residents, to include but not limited to dirty tube feeding poles, dirty bedside tables, fall mats, microwaves, sinks in the nourishment rooms, dirty walls, dirty floors & floor tiles, and/or dirty ceiling, window sills with accumulation of dusts. Findings of this audit is documented on "Quality Control Inspection-Housekeeping" located in the facility compliance binder. Correction of identified items will be rectified by the Housekeeping Supervisor by 06/06/2018. Any resident area identified with concerns and not rectified by 06/06/2018 will be removed from resident care usage until rectified.

SYSTEMIC CHANGES
Effective 06/06/2018, a maintenance work book will be placed at each nursing station where any maintenance issue(s) can be recorded by any staff member. Maintenance Supervisor will check these books daily (Monday to Friday). Any identified areas of concerns noted in the maintenance book will be addressed promptly by the maintenance supervisor or through an appropriate contracted repair vender. Any maintenance needs on the week-end that requires immediate attention, a maintenance supervisor or the

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F 584	Continued From page 14	F 584	Executive Director will be contacted by staff on duty. Any identified areas of concerns noted on the weekends will be addressed by the maintenance supervisor or through an appropriate contracted repair vender Mondays through Fridays for non-emergency findings, and promptly for emergency maintenance needs identified. Effective 05/31/2018, new Housekeeping/Laundry Supervisor hired, to manage the facility Housekeeping and Laundry services. This will ensure Housekeeping staff are informed of the expectation and routine duties they are responsible for on a daily basis. Effective 06/06/2018, Housekeeping/Laundry Supervisor re-established a cleaning assignment for housekeeping staff on duty to ensure each resident room is cleaned and sanitized in a daily basis. Housekeeping staff will communicate with licensed nurse on duty to aide moving the resident when needed in order to clean residents' room. This will be done while honoring residents choices. Effective 06/06/2018, revised deep cleaning schedule put forth by the housekeeping/Laundry supervisor for each room to be deep cleaned at least once monthly, by the Housekeeping staff. 100% of current facility employees, to include full time, part time and as needed employees, will be re-educated on the	

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F 584	Continued From page 15	F 584	maintenance request log and procedure to request any maintenance needs. This education will be completed by 06/06/2018, by Maintenance Director, Staff Development Coordinator and/or Executive Director, any staff not educated by 06/06/2018 will not be allowed to work until educated. This education will also added to new hire process for all new employees effective 06/06/2018 and will be provided annually. Housekeeping Supervisor and/or Executive Director, will complete 100% education for all current housekeeping and laundry employees to include full time, part time and as needed employees about cleaning procedures. The emphasis of this education was to clarify each housekeeping duties and responsibilities, on cleaning of floors and surfaces, corners, dusting, cleaning spider webs and cleaning of any dried substances. Likewise, housekeeping staff were educated on inspecting privacy curtain for cleanliness and report to the supervisor immediately if a privacy curtain is unclean, or does not provide full visual privacy. Any Housekeeping and/or Laundry employee not educated by 06/06/2018 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new housekeeping and laundry employees effective 06/06/2018. MONITORING PROCESS Effective 06/06/2018, Executive Director	

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F 584	Continued From page 16	F 584	and/or Director of Nursing will review maintenance work books to ensure compliance with work orders. This review will be completed daily for 2 weeks, weekly x 2 weeks, then monthly x 3 months or until the pattern of compliance is maintained. Findings of this monitoring process will be reported to facility quality assurance and performance improvement committee by the Executive Director and/or Director of nursing monthly x 3 months or until pattern of compliance is achieved. This plan will be modified according to outcomes or as needed and determined by QAPI committee. Effective 06/06/2018, Housekeeping supervisor will complete environmental cleanliness audits weekly x 4 weeks, then monthly x 3 months to assure floors, privacy curtain and surfaces are cleaned properly. Findings of this monitoring process will be reported to facility quality assurance and performance improvement committee by the Executive Director and/or Housekeeping Supervisor monthly x 3 months or until pattern of compliance is achieved. This plan will be modified according to outcomes as needed and determined by QAPI committee. RESPONSIBLE PARTY Effective 06/06/2018, the Executive Director, Maintenance Director and/or House Keeping supervisor will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial	

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F 584	Continued From page 17	F 584	compliance. Compliance Date: 06/06/2018.	
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, record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment to reflect restorative nursing services were provided for 2 of 2 sampled residents in the facility ' s restorative nursing program (Resident #58 and Resident #60); and failed to accurately code the MDS assessment to indicate the resident's dental status for 1 of 3 sample residents reviewed (Resident #45). The findings included: 1. Resident #58 was admitted to the facility on 1/31/14 with re-entry from a hospital on 4/1/15. His cumulative diagnoses included dementia and a history of cerebrovascular accident (stroke). A review of Resident #58 ' s medical record included a Restorative Nursing Referral dated 11/29/17. The resident was referred for passive range of motion (ROM) for all joints of the left arm and assistance to apply a splint to his left hand 4 - 6 hours as tolerated. Further review of Resident #58 ' s medical records revealed a second Restorative Nursing Referral (dated 1/4/18) instructed the following: "Passive and/or Active	F 641	F641 ROOT CAUSE MDS nurse #1, MDS nurse #2, and the facility Executive Director discussed with the Consultant from the contracted facility management and consulting company on 05/28/2018 to identify the root cause of this alleged noncompliance. The root cause analysis concluded that, Minimum Data Set (MDS) nurse #2 failed to assess and code resident #58 & #60 for a restorative program in Section O, due to misinterpretation and confusion by MDS nurse #2 on how to accurately code restorative nursing program in MDS when the criteria needed for coding meet RAI guideline but not meeting North Carolina State Medicaid Oversight Vender guidelines for coding (Myers & Stauffer), which are stricter than RAI guidelines. Likewise the facility root cause analysis concluded that MDS nurse failed to code resident #45 for having natural teeth on the dental section of MDS 3.0 per RAI guidelines. It was further identified that,	6/6/18

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F 641	Continued From page 18 ROM: In bed, gently open-close left leg 30x (times). Gently bend and straighten left knee and bend right knee 30x each. Ankle pumps 30x each leg. Bed Mobility: Place 2 pillows under left knee, one under right knee, one along left hip." A review of the resident ' s quarterly MDS (Minimum Data Set) assessment dated 4/5/18 revealed the resident had severely impaired cognitive skills for daily decision making. The resident required extensive assistance from staff for bed mobility, eating and toileting. He was totally dependent on staff for transfers, locomotion on and off the unit, dressing, and personal hygiene. Section O of the MDS assessment did not indicate the resident had been involved in the facility ' s restorative nursing program within the 7-day look back period. A review of Resident #58 ' s comprehensive care plan (dated 3/28/17 and revised 4/5/18) included an area of focus related to his Activities of Daily Living (ADL) self-care deficit. The care plan approaches included, in part: left hand splint as tolerated; and, positioning with pillows when in bed as indicated. An interview was conducted on 5/9/18 at 4:15 PM with the facility ' s Staff Development Coordinator (SDC). During the interview, the SDC reported she assumed responsibility for overseeing the facility ' s restorative nursing program. Upon inquiry, the SDC reported Resident #58 was on the restorative nursing program. She stated a Restorative Aide (RA) worked with this resident 6 days a week. The SDC reported that she herself followed all of the residents in the restorative program every month and assessed how each resident was doing.	F 641	this alleged noncompliance resulted from the error by the facility MDS nurse of not completing a thorough oral assessment before coding an MDS assessment for resident #45. IMMEDIATE ACTION TAKEN The MDS assessment for resident #58 ARD 04/05/2018 modified on 6/4/2018 to reflect a restorative nursing program on the look back period per RAI guidelines in section O of MDS by MDS Nurse #1 the modified MDS assessment will be transmitted on 6/4/2018 by MDS nurse #1. The MDS assessment for resident #60 ARD 04/05/2018 modified on 6/4/2018 to reflect a restorative nursing program on the look back period per RAI guidelines in section O of MDS by MDS Nurse #1 the modified MDS assessment will be transmitted on 6/4/2018 by MDS nurse #1. The MDS assessment for resident #45 ARD 03/30/2018 modified on 6/4/2018 to reflect some natural teeth are present on the look back period per RAI guidelines in section L 0200 of MDS by MDS Nurse #1, the modified MDS assessment was transmitted on 6/4/2018 by MDS nurse #1. IDENTIFICATION OF OTHERS 100% audit for current residents most recent MDS assessment was completed by the MDS Coordinator #1 and MDS Coordinator #2 on 5/30/18, 5/31/18 and 6/1/18 to determine if any other resident with restorative nursing program in the	

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F 641	Continued From page 19 An interview was conducted on 5/10/18 at 10:11 AM with MDS Nurse #1. After reviewing Resident #58 ' s quarterly MDS assessment dated 4/5/18, the MDS nurse was asked if this assessment should have indicated the resident was involved in the facility ' s restorative nursing program. She reported that MDS Nurse #2 had completed the 4/5/18 assessment for Resident #58. MDS Nurse #1 stated it was possible one of the MDS coding criteria for the restorative nursing program may not have been met during the 7-day look back period. A follow-up interview was conducted on 5/10/18 at 10:50 AM with the SDC and the facility ' s Director of Nursing (DON). During the interview, the SDC reported Resident #58 received 15 minutes of restorative nursing services 6 days each week since he was referred to the program. The DON reported she was having some difficulty accessing the documentation for the restorative nursing services provided. She explained the facility was transitioning from paper to electronic records. An interview was conducted on 5/10/18 at 12:25 PM with the facility ' s Restorative Aides (RAs). The DON and SDC were present at the time of the interview. Upon inquiry, RA #1 reported Resident #58 was on her caseload and RA #2 stated she filled in to provide these restorative services on an as needed basis. RA #1 reported 15 minutes of restorative services were provided for Resident #58 six times per week. She recalled the resident had been on the restorative program since November of 2017. An interview was conducted on 5/10/18 at 12:35	F 641	look back period was coded appropriately per RAI guidelines in section O of MDS 3.0. The results of the audit indicated no other residents with a restorative nursing program was coded inaccurately per RAI guidelines in section 0 of MDS 3.0. Findings of this audit is documented on "MDS accuracy audit tool" located in the facility compliance binder. 100% audit for current residents most recent MDS assessment was completed by the MDS Coordinator #1 and MDS Coordinator #2 on 5/30/18, 5/31/18, 6/1/18 & 6/4/18to determine resident's oral/dental status was coded accurately in section L of MDS 3.0. The results of the audit indicated one other residents was coded inaccurately per RAI guidelines in section L of MDS 3.0. MDS nurse #1 modified MDS assessment identified on audit to correct the coding in section L on 6/5/2018. Modified assessment was transmitted and accepted on 6/5/2018. Findings of this audit is documented on "MDS accuracy audit tool" located in the facility compliance binder. SYSTEMIC CHANGES Effective 6/6/2018, Residents who receive restorative nursing care under restorative program will be coded in MDS 3.0 per RAI guidelines, The Facility will ensure each resident on the program has all components of the program as detailed in the RAI guidelines. Chief Clinical Officer from the contracted	

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F 641	Continued From page 20 PM with the facility ' s DON and Administrator. During the interview, the Administrator stated she would expect Resident #58 ' s MDS assessment to be coded, "in accordance with the RAI (Resident Assessment Instrument) manual." Documentation of the restorative nursing services provided to Resident #58 in March 2018 and April 2018 was provided by the facility on 5/10/18 at 3:15 PM. The records were entitled, "Restorative Care-Splint or Brace Assistance Care Plan and Flow Record" and "Restorative Care-Passive ROM Care Plan and Flow Record." Upon review, these records indicated Resident #58 received at least 15 minutes of restorative nursing services each day during the months of March 2018 (with the exception of 3/4/18, 3/14/18, and 3/15/18) and April 2018 (with the exception of 4/15/18). Upon further review, the April 2018 records included Restorative Nursing Care Plans as follows: 1) Problem(s): Resident requires the use of a splint or brace to prevent contractures or progression of existing contracture. A hand-written notation read, "Left hand splint 4 - 6 hrs (hours) as to tolerated." Goal(s): Will wear "left" (hand-written) (splint/brace) without complications x 1 month. Will evidence no decline in contracture status x 1 month. Intervention(s): Will Don/Doff splint/brace per physicians order. Remind resident of need for splint/brace; Apply/assist resident to Don/Doff device at designated times; Monitor for swelling, redness, pain or skin breakdown; Document application/refusal of splint daily; Ensure device is clean and in good condition; Ensure affected area is clean and dry prior to splint/brace application; Report any changes to the restorative supervising	F 641	Management and Consulting Company revised the MDS data collection tool on 6/1/2018, by adding sections that will require MDS nurse to review potential restorative nursing programs and oral/dental status of resident. The revised data collection tool will be utilized effective 6/6/2018. Chief Clinical Officer from the contracted Management and Consulting Company conducted re-education on 6/4/2018 to Director of Nursing, Assistant Director of Nursing and Staff Development Coordinator on components necessary for a restorative program required for the program to be coded accurately in MDS per Resident Assessment Instruments (RAI) guidelines. This education covers meaning of restorative nursing program, how to establish problem, goals, approaches, proper documentation, and detailed evaluation of the program documentation. Effective 06/06/2018, education on restorative nursing program documentation requirements for accurate coding of MDS will be added to new hires orientation education for MDS nurses, Director of Nursing, Assistant Director of Nursing and Staff Development Coordinator. This education will also be provided annually. Chief Clinical Officer from the contracted Management and Consulting Company conducted re-education on 6/4/2018 to MDS nurse #1 and MDS nurse #2 on accurate coding of MDS using Resident	

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F 641	Continued From page 21 nurse. Nursing Evaluation: A hand-written notation read, "Resident continues on splints. No complications noted. Will continue program as tolerated." The Care Plan was signed by the Restorative Nursing Supervisor and dated 4/1/18. 2) Problem(s): Resident has impairments/limitations with range of motion. A hand-written notation read, "Passive ROM left arm all joints." Goal(s): Will sustain/improve ROM to "UE" (hand-written to designate upper extremity) as evidenced by continued ability to participate in "passive" (hand-written) ROM exercises x 1 month. Intervention(s): Explain ROM to resident prior to and during exercise; Provide privacy during ROM exercises; Perform ROM to the extremity(s) per restorative referral for at least 15 minutes during the course of the day; Monitor for complaints of pain, discomfort or changes in ROM; Encourage and praise all efforts to participate in ROM; Use devices as recommended; Document performance daily; Report any changes to restorative supervising nurse. Nursing Evaluation: A hand-written notation read, "Continues on PROM (passive range of motion). No complications noted." The Care Plan was signed by the Restorative Nursing Supervisor and dated 4/1/18. A follow-up interview was conducted with the SDC on 5/10/18 at 3:20 PM. During the interview, the SDC confirmed she had signed Resident #58 ' s restorative care plans as the Restorative Nursing Supervisor on 4/1/18. Upon the facility ' s request, an interview was conducted on 5/10/18 at 5:50 PM with MDS	F 641	Assessment Instruments (RAI) guidelines. This education covers coding requirements and supportive documentation for each item coded in MDS, specifically related to section O and Section L of MDS 3.0 assessment. Effective 06/06/2018, education on the accurate coding of MDS will be added to new hires orientation education for MDS nurses, Director of Social Services, Activities Director, and the Dietary Manager (DM). This education will also be provided annually for MDS nurses, Director of Social Services, Activities Director, and the Dietary Manager (DM). MONITORING PROCESS Effective 06/06/2018, prior to submission, MDS Nurse #1 will review section O and Section L 0200 of MDS 3.0 completed by MDS nurse #2 (and vice versa) to ensure that active restorative nursing programs and oral/dental status is coded accurately per RAI guideline respectively. These reviews will take place Monday through Friday, prior to submission for 2 weeks on all completed MDS assessments, 50% of all completed MDS assessments weekly for 2 weeks, then 25% of all completed MDS assessments monthly for 3 months or until the pattern of compliance is achieved. Any inaccurate coding identified will be noted and corrected before submission by MDS nurse #1 or #2 (whoever is completing the audit). Findings of this monitoring process will be documented on MDS accuracy	

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F 641	Continued From page 22 Nurse #1 and MDS Nurse #2. MDS Nurse #2 was identified as the nurse who completed Resident #58 ' s MDS assessment dated 4/5/18. During the interview, MDS Nurse #2 reported she did not code this resident ' s MDS assessment to reflect his involvement with the restorative nursing program because she did not feel it met the coding criteria. MDS Nurse #2 stated the goals of the restorative care plan for this resident were very vague and there was no indication as to how his progress would be measured. When asked, both MDS Nurse #1 and MDS Nurse #2 acknowledged the restorative nursing supervisor completed/signed Resident #58 ' s restorative care plan within the 7-day period of time required by the RAI manual. 2. Resident #60 was admitted to the facility on 8/21/06 with cumulative diagnoses which included Alzheimer's disease and a cerebrovascular accident (stroke). A review of the resident's quarterly MDS (Minimum Data Set) assessment dated 4/2/18 revealed Section O of the MDS assessment did not indicate the resident had been involved in the facility's restorative nursing program within the 7-day look back period for passive range of motion and splinting. A review of Resident #60's comprehensive care plan (dated 3/25/18 and revised 3/31/18) included an area of focus related to Activities of Daily Living (ADL) self-care deficit. The care plan approaches included, in part: bilateral hand and elbow splints as tolerated. A review of the Restorative Care-Splint or Brace Assistance Care Plan and Flow Record" and "Restorative Care-Passive ROM Care Plan and Flow Record" indicated Resident #60for the months of March, April and May 2018 received at least 15 minutes of restorative nursing services	F 641	monitoring tool located in the facility compliance binder. Effective 06/06/2018, MDS nurse #1 or #2 will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly X3 months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. RESPONSIBLE PARTY Effective 06/06/2018, the Executive Director, Director of Nursing and MDS nurses #1 &#2 will be ultimately responsible to ensure implementation of the plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance. Compliance Date: 06/06/2018	

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each day except for 4/1/18.
An interview was conducted on 5/9/18 at 4:15 PM with the facility's Staff Development Coordinator (SDC). During the interview, the SDC reported she assumed responsibility for overseeing the facility's restorative nursing program. Upon inquiry, the SDC reported Resident #60 was on the restorative nursing program. She stated a Restorative Aide (RA) worked with this resident 6 days a week. The SDC reported that she herself followed all the residents in the restorative program every month and assessed how each resident was doing.
An interview was conducted on 5/10/18 at 10:11 AM with MDS Nurse #1. After reviewing Resident #60 quarterly MDS assessment dated 4/5/18, the MDS nurse was asked if this assessment should have indicated the resident was involved in the facility's restorative nursing program. MDS Nurse #1 stated it was possible one of the MDS coding criteria for the restorative nursing program may not have been met during the 7-day look back period.
An interview was conducted on 5/10/18 at 12:35 PM with the facility's DON and Administrator. During the interview, the Administrator stated she would expect MDS assessment to be coded, "in accordance with the RAI (Resident Assessment Instrument) manual."
Interview on 05/10/18 at 4:06 PM with Restorative Aide (RA) #1 who stated Resident #60-received restorative services 6 days a week that included application of the splints from 6 am to 9 AM and passive range of motion. RA #1 stated this resident had been on the restorative program since 9/5/17.

The facility used the "Restorative Care-Splint or Brace Assistance Care Plan and Flow Record"

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and "Restorative Care-Passive ROM Care Plan and Flow Record." Upon review, these records for March, April and May 2018 indicated Restorative Nursing Care Plans as follows:

1) Problem(s): Resident requires the use of a splint or brace to prevent contractures or progression of existing contracture. A hand-written notation read, bilateral elbow splints and hand splints to be worn as tolerated

Intervention(s): Will Don/Doff splint/brace per physician's order. Remind resident of need for splint/brace; Apply/assist resident to Don/Doff device at designated times; Monitor for swelling, redness, pain or skin breakdown; Document application/refusal of splint daily; Ensure device is clean and in good condition; Ensure affected area is clean and dry prior to splint/brace application; Report any changes to the restorative supervising nurse.

Nursing Evaluation: A hand-written notation read, Resident continues with B/L[bilateral] elbow splints with hand splints. No complications noted at this time. Continue with splinting program.

The Care Plan was signed by the Restorative Nursing Supervisor and dated 3/3/18.

2) Problem(s): Resident has impairments/limitations with range of motion. A hand-written notation read, PROM (Passive ROM) all joints in both arms .

Goal(s): Will sustain/improve ROM to "UE" (hand-written to designate upper extremity) as evidenced by continued ability to participate in "passive" (hand-written) ROM exercises x 1 month.

Intervention(s): Explain ROM to resident prior to and during exercise; Provide privacy during ROM exercises; Perform ROM to the extremity(s) per restorative referral for at least 15 minutes during the day; Monitor for complaints of pain,

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discomfort or changes in ROM; Encourage and praise all efforts to participate in ROM; Use devices as recommended; Document performance daily; Report any changes to restorative supervising nurse.
Nursing Evaluation: A hand-written notation read PROM tolerated without complications. Will continue on restorative program. Continues PROM. No complications noted.

The Care Plan was signed by the Restorative Nursing Supervisor (RNS) but not dated in March 2018. There was a dated and signed careplan on 4/3/18.

3. Resident #45 was admitted to the facility on 3/23/18 and diagnoses included Alzheimer ' s, diabetes and chronic kidney disease.

An admission minimum data set (MDS) dated 3/30/18 fir Resident #45 revealed she had no natural teeth or tooth fragments.

A care plan dated 4/5/18 stated Resident #45 had no natural teeth and was missing one of her dentures. Interventions included to make a dental appointment for a dental exam as indicated, assist with dental care to reduce irritation from food and monitor my gums for irritation or sores.

An observation on 5/8/18 at 8:57 am of Resident #45 revealed she had natural teeth present on her bottom gum.

An observation on 5/9/18 at 10:23 am of Resident #45 with the MDS nurse revealed she had some natural teeth present on the bottom gum.

An interview with the MDS nurse on 5/9/18 at

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F 641	Continued From page 26 10:26 am revealed she had completed the dental section of the admission MDS dated 3/30/18 for Resident #45. She stated when she coded that section she may have been just referring to the residents top teeth. The MDS nurse added she probably should have checked the resident had missing and broken natural teeth. An interview on 5/10/19 at 6:42 pm with the Administrator revealed it was her expectation that the MDS be coded correctly to reflect the health condition of the resident.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline	F 655		6/6/18

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F 655	Continued From page 27 care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete the baseline care plan within 48 hours of admission and failed to review the baseline care plan with the responsible party for 1 of 5 new admissions (Resident #32). Findings Included: Resident #32 was admitted to the facility on 2/27/18 and diagnoses included muscle weakness, abnormalities of gait and mobility, dementia with behavioral disturbances, glaucoma and depressive disorder. Review of a fall risk assessment dated 2/27/18 for Resident #32 identified a score of 26 (a score of 10 or higher was defined as high risk for falls).	F 655	F655 ROOT CAUSE This alleged noncompliance was resulted from the facility failing to complete baseline care plan within 48 hours of admission and failed to review the baseline care plan with responsible party. The root cause analysis also concluded that, the facility staff lack of awareness of regulatory requirements for baseline care plan to be completed within 48 hours is another causative factor for this alleged noncompliance. IMMEDIATE ACTION	

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F 655	Continued From page 28 Review of a baseline care plan dated 2/27/18 for Resident #32 revealed the safety section which included history of falls and fall related injuries, social services section, activity of daily living section, summary of baseline care plan narrative, completion date, and completion signatures including signature of resident / resident representative were blank. Review of the admission minimum data set (MDS) dated 3/13/18 for Resident #32 had impaired cognition. An interview on 5/10/18 at 9:00 am with the MDS nurse revealed the baseline care plans were started by the Admissions Director and then each discipline completed their section. She stated the goal was to meet with the resident and / or the resident ' s responsible party within 72 hours of admission to review the baseline care plan with them. The MDS nurse added they were supposed to have the resident and /or responsible party sign the baseline care plan and give them a copy. She stated there wasn ' t one person designated to ensure that the baseline care plan was completed within 48 hours of admission and reviewed with the resident and / or responsible party; anyone on the interdisciplinary team could do that. An interview on 5/10/18 at 3:10 pm with the Admission Director (AD) revealed when a resident was admitted he would print out a blank copy of the baseline care plan, complete the top section (identification information) and place it in the residents chart. The AD stated either he or the Social Worker (SW) would try and make arrangements to meet with the resident ' s family within 72 hours of admission. He added the MDS	F 655	On 6/1/2018, it was determined that the facility had already developed a comprehensive care plan for resident #32, that includes necessary healthcare information necessary to properly care for resident #32. On 6/1/2018 the facility provided the copy of comprehensive care plan that include the goals for the resident, copy of medication list, dietary restriction and/or services and treatment to be administered by the facility and personnel acting on the behalf of the facility. No further actions taken for resident #32. IDENTIFICATION OF OTHERS All residents recently admitted have the potential to be affected. 100% of residents who were admitted within the last 30 days were audited on 6/1/2018 by the DON, ADON, SDC, MDS Nurse #1, and/or MDS nurse #2. The audit focus on determining whether the baseline care plans were completed within 48 hours of admission or not. The results of the audit indicated no other residents identified without a baseline care plan completed within 48 hours of admission. Findings of this audit is documented on "Baseline Care Plan audit tool" located in the facility compliance binder. 100% of residents who were admitted within the last 30 days were audited on 6/1/2018 by the DON, ADON, SDC, MDS Nurse #1, and/or MDS nurse #2. The audit focus on determining whether	

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F 655	Continued From page 29 nurse or SW were primarily in charge of this process. He stated he had not been providing the families with a copy of the baseline care plan or having them sign that they received it. The AD added he could not recall if the baseline care plan was reviewed with Resident #32 ' s family. An interview on 5/10/18 at 3:24 pm with the SW revealed a resident ' s baseline care plan was typically completed within 48 to 72 hours of admission. She stated all disciplines participated in completion of the baseline care plan. The SW explained she was not sure if the MDS nurse provided a copy of the baseline care plan to the resident and / or their family, but she typically did. She added there was a place on the baseline care plan for the resident and / or family to sign that it had been reviewed with them, but sometimes they would forget to get the signature. The SW could not confirm that this was completed with Resident #32 ' s family. An attempt to reach Resident #32 ' s responsible party was attempted on 5/10/18 at 2:56 pm with no response or returned call. An interview on 5/10/18 at 6:42 pm with the Administrator revealed it was her expectation that baseline care plans were accurate, complete and reviewed with the resident and / or family member per the regulation.	F 655	resident and or responsible party received a summary of the baseline care plan after its completion. The results of the audit indicated that no other residents identified. Findings of this audit is documented on "Baseline Care Plan audit tool" located in the facility compliance binder. SYSTEMIC CHANGES Effective 6/6/2018, Baseline care plan will be completed within 48 hours of admission. MDS nurse #1 and MDS nurse #2 will provide summary to the resident and/or resident representative upon its completion. Effective 6/6/2018, the facility will provide the resident and their representative the summary of the Baseline care plan that includes but is not limited to: The initial goals of the resident, a summary of the resident's medications and dietary instructions, any services and treatments to be administered by the facility and personnel acting on behalf of the facility and any updated information based on the details of the comprehensive care plan, as necessary. MDS nurse #1 & #2 will be ultimately responsible to ensure these needed information are given. Chief Clinical Officer from the contracted Management and Consulting Company revised the revised the baseline care plan tool on 6/1/2018. The revised tool will address resident risk areas as identified on risk assessments and will also assure all sections were present to reflect	

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F 655	Continued From page 30	F 655	resident initial plan of care. The revised baseline care plan tool will be utilized effective 6/6/2018. Moving forward, effective 06/06/2018, the Admissions Director will initiate the baseline care plan and place in the resident chart prior to resident arrival. Once resident is present in the facility, the admitting nurse will complete the baseline care plan based on information provided to the facility from previous level of care. This baseline care plan will continue to be updated by facility nursing staff as resident plan of care changes and/or the comprehensive care plan is initiated. Once the comprehensive care plan is initiated, the MDS Nurse will remove the baseline care plan from the active record to be filed in residents inactive medical record. 100% education of all current Licensed nurses, to include full time, part time and our as needed nursing staff, will be completed by Director or Nursing, Assistant Director of Nursing and/or Staff Development Coordinator. This education will provide an emphasis on the initiation,& completion of baseline care plan within 48 hours, periodic updates and necessities to address risk factors as identified on admission assessment onto resident's baseline care plan. This education will be completed by 6/6/2018 for all licensed nurses. Any licensed nurse not educated by 6/6/2018 will not be allowed to work until educated. Effective 06/06/2018, education on completion, and	

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revision of baseline care plan will be added to new hires orientation education for Licensed nurses. This education will also be provided annually.

MONITORING PROCESS

Director of Nursing, Assistant Director of nursing, Staff Development Coordinator, as well as MDS nurse (#1 & #2), will monitor compliance of the baseline care plan completion by conducting clinical meeting daily (Monday-Friday), effective 06/06/2018, this meeting covers any change of resident condition that occurred from the prior daily clinical meeting, review of physician orders written from prior clinical meeting, any admission/discharges occurred from the last clinical meeting and/or any incidents or accidents occurred from the prior clinical meeting. The audit and discussion will ensure baseline care plans are developed and updated timely. Findings from this meeting will be documented on a daily clinical report form and filed in clinical meeting binder after proper follow ups are completed.

Effective 6/6/2018, Director of Social services and/or Executive Director will review all new admits 72 hours after the admission to validate baseline care plan was completed within 48 hours. The Social worker and the Executive director will review same group of residents at least after 21 days of admission to validate that a summary of resident's baseline care plan was provided to the

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F 655	Continued From page 32	F 655	resident and their representative. Any negative findings will be addressed promptly. This monitoring process will take place for all new admits daily (M-F) for four weeks then monthly for three months or until the pattern of compliance is established. Findings of this monitoring process will be documented on Baseline Care Plan monitoring tool located in facility compliance binder. Effective 6/6/2018; Director of nursing will review the completion of priority list weekly x 4 weeks, then monthly x 3 months. Director of Nursing will report findings to facility Quality Assurance Performance Improvement Committee for any additional monitoring needs or alteration of this requirement. RESPONSIBLE PARTY Effective 06/06/2018, the Executive Director and the Director of Nursing will be ultimately responsible to ensure implementation of the plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate	F 676		6/6/18

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F 676	Continued From page 33 that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to provide perineal care in a manner to prevent a urinary tract infection. The facility used the same basin of soiled water that was used to remove urine and stool to cleanse the resident's legs and feet. This was for 1 of 4 residents (Resident #60) sampled for activities of daily living.	F 676	F676 ROOT CAUSE Root cause analysis conducted revealed, the alleged noncompliance resulted from failure by an employee NA#2 to follow proper steps for perineal care, infection prevention and control practices, and	

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F 676	Continued From page 34 Findings included: Resident #60 was admitted to the facility on 8/21/06 with cumulative diagnoses which included Alzheimer's disease and a cerebrovascular accident (stroke). A review of the resident's quarterly MDS (Minimum Data Set) assessment dated 4/2/18 coded the resident with severe cognition impairment, totally dependent on staff for personal hygiene and bathing. Additionally, Resident #60 was coded as incontinent of bowel and bladder. Review of the care plan dated 3/25/18 and revised 3/31/18 revealed in part a problem of activities of daily living (ADL) self-care deficit related to coma status and contractures of the upper and lower extremities'. The goal was for the resident to receive ADL assistance. The interventions included to provide total assistance with bathing, dressing and personal hygiene. Observation on 05/10/18 at 11:52 AM during incontinence care performed by Nursing Assistant (NA) #2 revealed Resident #60 had experienced an episode of incontinent of urine and stool. NA #2 used a basin of water with a no rinse skin cleanser. NA #2 cleansed the resident's perineal area 4 times in an front to back then back to front motion cleansing the urine and stool off of the resident's skin. Then NA #2 removed the blue and yellow heel protectors and washed the resident with the same water used to cleanse the urine and stool off the resident. Interview on 05/10/18 at 12:22 PM with NA #2 who stated he was aware that cleansing the perineal area for females should be from a front to back direction. NA #2 stated the basin of water was sudsy and did not change the water	F 676	general hygiene practices. This was evident based on the statement stating, “NA #2 removed the blue and yellow heel protectors and washed the resident with the same water used to cleanse the urine and stool off the resident”. The root cause analysis also revealed that, the facility failed to provide a continuous education specifically related to perineal care with return demonstration. IMMEDIATE ACTION On 05/31/2018, nursing assistant #2 was re-educated by the Staff Development Coordinator on providing incontinent care to female residents and completed an ‘Incontinent Skills Checklist’. On 05/31/2018, resident #60 was provided ADL care per incontinent skills checklist by Nursing Assistant #2, while observed by facility Staff Development Coordinator, NA#2 followed the proper procedures as outline on step by step checklist utilized. IDENTIFICATION OF OTHERS All dependent residents have the potential to be affected by the alleged deficient practice. On 6/1/2018 Staff development coordinator observed nurse aides on duty to identify if any resident receive incontinent care without proper technique and ensure nursing staff use the correct perineal care techniques, as well as, change water basin as appropriate to	

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F 676	Continued From page 35 because" I did not believe the water was dirty. " Interview on 05/10/18 at 1:43 PM with the Director of Nurses revealed she expected staff when performing perineal care for females staff should cleanse from a front to back motion. The DON did not provide an expectation of obtaining fresh water in the basin.	F 676	prevent an infection. No other resident was identified to be affected by this alleged non-compliance. Findings of this audit is documented on the 'ADL Observation Audit Tool' maintained in the facility compliance binder. SYSTEMATIC CHANGES Effective 06/06/2018, the facility will provide perineal care to all current dependent residents, in a manner to prevent a urinary tract infection. Proper techniques such as not using the same basin of soiled water that was used to remove urine and stool to cleanse the resident's legs or other parts of the body regardless of whether the water looks clean or not will be employed 100% education of all current nursing staff, to include full time, part time and as needed nursing staff, will be completed by Director or Nursing, Assistant Director of Nursing and/or Staff Development Coordinator. This education will provide an emphasis incontinence care for dependent residents. This education will be completed by 06/06/2018, any staff not educated by 06/06/2018 will not be allowed to work until educated. This education was also added to new hire process for all new employees effective 06/06/2018 and will be provided annually. 100% of all current certified nursing assistants, to include full time, part time and our as needed certified nursing assistance, will be observed giving	

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F 676	Continued From page 36	F 676		

perineal care to dependent residents by Director or Nursing, Assistant Director of Nursing and/or Staff Development Coordinator for the return demonstration. Each nursing assistant will be observed performing incontinence care for at least one resident. The return demonstration will be conducted and documented in the “Incontinence Care Observation Checklist”. The return demonstration and the checklist will be completed by 06/06/2018, any certified nursing aide not re-educated by 06/06/2018 will not be allowed to work until checklist is completed. This checklist was also added to new hire process for all new nursing aide employees effective 06/06/2018 and will be provided annually.

MONITORING PROCESS

Effective 06/06/2018, the Director of Nursing, Assistant Director of Nursing and/or Staff Development Coordinator will complete the random audit of nursing aides and/or nurses providing incontinence care for five residents to ensure care was provided correctly. Findings from this monitoring process will be documented on an ‘Incontinence Care Monitoring Tool’ maintained in the facility compliance binder. This monitoring process will take place daily for 2 weeks then 3x/week for two more weeks, then weekly for 2 weeks then monthly for 3 months or until the pattern of compliance is maintained. This monitoring process will be completed on random shifts to cover all three shifts to include week ends as

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F 676	Continued From page 37	F 676	well. Effective 06/06/2018, Director of Nursing, Assistant Director of Nursing and/or Staff Development Coordinator will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. RESPONSIBLE PARTY Effective 06/06/2018, the center Executive Director and the Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance. Compliance date 6/6/2018	
F 914 SS=E	Bedrooms Assure Full Visual Privacy CFR(s): 483.90(e)(1)(iv)(v) §483.90(e)(1)(iv) Be designed or equipped to assure full visual privacy for each resident; §483.90(e)(1)(v) In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by:	F 914		6/6/18

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F 914	Continued From page 38 Based on observation and staff interviews the facility failed to provide sufficient privacy curtains with functional hooks and ceiling tracks to provide full visual privacy in Rooms #115, #116, #125, #131, #303, and #308. This was evident in 2 of 3 resident care units. Findings included: Observation on 05/09/18 at 8:30 AM in Room 125 revealed no privacy curtain for Bed A Observation on 05/09/18 at 8:45 AM in Room #131B revealed the privacy curtain hooks did not flow freely through the tracks. The hooks became stuck and created a 120-inch gap for bed B and for A bed a gap of 48 inches of insufficient curtains. Observation on 05/09/18 at 8:47 AM revealed in Room #303 a 72-inch gap of insufficient privacy curtain. Observation on 05/09/18 at 8:50 AM revealed in Room #308 A bed the hooks were stuck in the track which created a 60-inch gap. For B bed the hooks would not flow freely creating a 24-inch gap. Observation on 5/9/18 at 1:20 PM revealed between A and B bed in Room #116 there was insufficient curtain of 36 inches. Observation on 05/08/18 at 1:33 PM revealed insufficient privacy curtains in Room #115A. Interview on 05/09/18 at 02:55 PM with the Housekeeping manager revealed all house keepers are responsible replacing privacy curtains. A vendor came in to measure new	F 914	F914 ROOT CAUSE This alleged noncompliance was resulted from the housekeeping staff not being educated that semi-private rooms are to have full visual privacy. IMMEDIATE ACTION On 05/31/2018, the privacy curtain for Room #125 for Bed A was replaced with curtain to provide full visual privacy by the Housekeeping Supervisor. On 05/31/2018, the privacy curtain hooks for Room #131B was fixed so it would flow freely and provided full visual privacy by the Maintenance Supervisor. On 05/31/2018, the privacy curtain for Room #303 was replaced with curtain to provide full visual privacy by the Housekeeping Supervisor On 05/31/2018, the privacy curtain hooks for Room #308A was fixed so it would flow freely and provided full visual privacy by the Maintenance Supervisor. On 05/31/2018, the privacy curtain hooks for Room #308B was fixed so it would flow freely and provided full visual privacy by the Maintenance Supervisor. On 05/31/2018, the privacy curtain for Room #116 between bed A and bed B was replaced with curtain to provide full visual privacy by the Housekeeping	

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F 914	Continued From page 39 curtains and hooks and was not sure how privacy was provided. Attempted to interview HK #1 and #2 but was unsuccessful. Interview on 5/10/18 at 6:53 PM the administrator stated the facility had sufficient curtains to replace in rooms and the staff may have placed the wrong sizes in the resident rooms. The administrator stated her expectation was to provide full visual privacy to residents.	F 914	Supervisor. On 05/31/2018, the privacy curtain for Room #115 for Bed A was replaced with curtain to provide full visual privacy by the Housekeeping Supervisor. IDENTIFICATION OF OTHERS On 05/23/2018, the Housekeeping Supervisor and/or Regional Housekeeping Manager completed 100% audit of resident rooms required to provide full visual privacy. This audit was done to ensure privacy curtain for Bed A and Bed B provided full visual privacy and flowed freely with no gaps. This audit is documented on the 'Visual Privacy Audit Tool'. Findings from this audit was rectified immediately SYSTEMATIC CHANGES Effective 06/06/2018, and moving forward, Housekeeping to hang the curtains right away when replacing for deep cleans. Effective 06/06/2018, and moving forward, Housekeeping Supervisor will maintain par levels of six 6 large and 6 for small curtains. Housekeeping Supervisor and/or Executive Director, will complete 100% education for all current housekeeping and laundry employees to include full time, part time and as needed employees about cleaning procedures. The emphasis of this education was on ensuring when privacy curtains are removed that they are	

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F 914	Continued From page 40	F 914	replaced immediately and the privacy curtains provide the resident with full visual privacy. Any Housekeeping and/or Laundry employee not educated by 06/06/2018 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new housekeeping and laundry employees effective 06/06/2018. MONITORING PROCESS Effective 06/06/2018, the Executive Director and/or Housekeeping Supervisor will complete a random audit of 5 resident room privacy curtains to assure full visual privacy. Findings from this monitoring process will be documented on a 'Privacy Curtain Monitoring Tool' maintained in the facility compliance binder. This monitoring process will take place daily (Monday through Friday) for 2 weeks then 3x/week for two more weeks, then weekly for 2 weeks then monthly for 3 months or until the pattern of compliance is maintained. RESPONSIBLE PARTY Effective 06/06/2018, the Executive Director, and/or House Keeping supervisor will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance. Compliance Date: 06/06/2018	
F 925	Maintains Effective Pest Control Program	F 925		6/6/18

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F 925 SS=E	Continued From page 41 CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews the facility failed to have an effective pest control program. Findings included: Interview on 05/07/18 at 1:10 PM with Resident #234 revealed she observed "bugs" in the room on 05/06/18. Interview on 05/08/18 at 02:19 PM with Resident #42 revealed she had issues with a big brown colored "roach" crawling on her bed a month ago (referring to April 2018). Review of the contracted pest control invoices revealed treatments had been performed on 1/25/18, 2/23/18 ,3/29/18, 4/3/18, 4/20/18, and 4/27/18. On 4/27/18 treatment the pest control company recommended the facility to cut back bushes, tree limbs, vines and weeds for pest control, prevent pest build up, trailing and harboring. In addition, a recommendation was made to clean out the gutters. Observation on 05/09/18 at 8:20 AM and witnessed by Nurse #---revealed in the bathroom shared by Room #116-118 revealed a live brown colored crawling insect on the floor. Interview on 05/10/18 at 11:31 AM with the Director of Maintenance (DOM) revealed he was unclear of who was responsible for pest control in	F 925	F925 ROOT CAUSE Based on root cause analysis by facility administrative staff, facility staff failed to report the sighting of insects as directed/expected. However the facility does have a Pest Control Program as required by regulation. IMMEDIATE ACTION Resident #234 discharged from the facility on 05/18/2018. Resident #42 room were inspected on 06/01/2018 for any pest activity Contracted licensed Pest control company, no further issues identified. IDENTIFICATION OF OTHERS On 06/01/2018, Licensed Pest Control company that provides services at the center did a complete pest audit, including full facility treatment inside and outside around perimeter of facility. No other issues related to pest control identified. SYSTEMIC CHANGES Effective 06/06/2018, the center Director	

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F 925	Continued From page 42 the facility. The DOM indicated the human resources coordinator takes care of the pest control. If the contractor from the company came to the facility he would help as much as he could. Continued interview revealed the DOM had observed live crawling insect on Unit 100 and a dead bug on Unit 200. Interview on 05/10/18 at1 PM with the administrator stated she expected the contract pest control company to be effective and that the human resource coordinator was responsible for the invoices.	F 925	of Maintenance, Director of Housekeeping and/or Executive Director, initiated a process for communication by facility employees by creating Maintenance Books at each nurse station, and revised the pest control book at receptionist desk. Those books will be utilized by facility staff to communicate all maintenance requests and/or any pest noted in the facility that need attention. The center Director of Housekeeping, and/or Maintenance Director will review the maintenance and pest control books daily (Monday through Friday) and address any identified maintenance and/or pest control related issue promptly effective 06/06/2018. Any negative findings will be documented on the pest control audit forms and maintained in the Daily meeting binder. Director of Maintenance, Director of Housekeeping and/or Executive Director, Director of Nursing (DON), Assistant Director of Nursing (ADON) and/or Staff Development Coordinator (SDC) will complete 100% education for all current facility employees, to include full time, part time and as needed employees on reporting any noted pests in the facility promptly in Maintenance Book at nurse station, and/or pest control book at receptionist desk. The emphasis of this education was on the importance of communicating any noted pest in the facility. This education will be completed by 06/06/2018, any employee not educated by 06/06/2018 will not be allowed to work until educated. This education will also be added on new hires	

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F 925	Continued From page 43	F 925	orientation process for all new employees effective 06/06/2018. MONITORING PROCESS Effective 06/06/2018, Executive Director, and/or Director of Nursing will monitor compliance by reviewing maintenance binders and Pest Control book to ensure compliance on both usage by facility staff and to ensure that the Maintenance Director and/or the Director of Housekeeping review the books daily (Monday through Friday). This monitoring process will take place weekly for four weeks, then monthly for three more months or until the pattern of compliance is maintained. Any issues identified during this monitoring process will be addressed promptly. Findings from this monitoring process will be documented on a pest Control Review form and filed in the facility compliance binder effective 06/06/2018. Effective 06/06/2018, Maintenance Director, Housekeeping Director, and/or the Executive Director, will monitor compliance by completing Pest Control audit by inspecting the facility for any evidence of any pests. This monitoring process will take place three times a week for four weeks, then weekly for eight more weeks, then monthly for 3 months or until the pattern of compliance is maintained. Any issues identified during this monitoring process will be addressed promptly. Findings from this monitoring process will be documented on a pest	

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F 925	Continued From page 44	F 925	Control Audit form and filed in the facility compliance binder effective 06/06/2018. Effective 06/06/2018, Maintenance Director, Housekeeping Director, and/or the Center Executive director will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until the pattern of compliance is maintained. The QAPI committee will modify this plan to ensure the facility attain and maintain substantial compliance. RESPONSIBLE PARTY Effective 06/06/2018, the center Executive Director and the Director of Maintenance and/or Housekeeping Supervisor will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	