STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345344	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA NURSING & REHABILITATION-HENDERSON	280 SOUTH BECKFORD DRIVE HENDERSON, NC 27536

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or	F 623		7/10/18

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

Electronically Signed | 06/29/2018

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F 623	Continued From page 1 (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice.	F 623		

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F 623	Continued From page 2 If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide the resident and resident representative a written notification for the reason for transfer to the hospital for 3 of 3 residents reviewed for hospitalization. (Resident #51, Resident #36 and Resident #70). The findings included: Example #1 Resident #51 was originally admitted to the facility on 3/20/18 with diagnoses including Chronic Obstructive Pulmonary Disease, Atherosclerotic heart disease, Type 2 Diabetes Mellitus without complications and Acute Kidney Failure. According to the most recent Admission Minimum Data Set (MDS) dated 3/27/18, Resident #51's cognition was intact. She required extensive assistance in most areas of activities of daily living.	F 623	F623 Notice Requirements before Transfer/Discharge CFR(s) 483.15(c)(3)-(6)(8) Residents affected: (1)Residents #51, #36 and #70 have had letters sent to the family members/representatives. Residents who have had a transfer/ discharge within the past 30 days the resident, family/representative will receive a notification of discharge. (2) Resident with Potential to be Affected Residents that have been sent to the hospital in the past 30 days will have transfer letter sent to the resident/family and/or representative. Staff Development Coordinator will in-service all staff on the	

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F 623	Continued From page 3 Resident #51 was admitted to the facility after being discharged from the hospital on 3/20/18. She was discharged to the hospital on 4/11/18 and was readmitted to the facility on 4/17/18. Resident#51 was discharged to the hospital on 4/30/18 and readmitted to the facility on 5/4/18. The resident was discharged to the hospital again on 6/12/18. There was no written notice of transfer documented in the resident's record noted to have been provided to the resident or the resident's representative. During an interview on 6/11/18 at 1:52 PM, Resident #51 revealed she had been discharged to the hospital three times since she had been in the facility. She revealed she had not received any written notification from the facility regarding her discharge to the hospital. During an interview with the Admissions Coordinator on 6/13/18 at 2:05PM she stated she did not send a letter to the resident or responsible party upon transfer to the hospital with an explanation of why the resident was transferred. She stated the nursing staff usually called the responsible party to let them know why the resident was going to the hospital. During an interview with the Administrator on 6/14/18 at 9:16AM he stated a letter was not being sent upon transfer to the resident or responsible party because phone calls were done. He stated the facility would begin sending a letter. During an interview with the Social Worker on 6/14/18 at 9:35AM she stated that she was responsible to send a notice to the Ombudsman	F 623	discharge notification requirements and process of notification beginning on 7/2/18 using the policy and procedure and transfer/discharge power point, until 100% of staff are in-serviced. The Social Worker/ Admissions Coordinator will send written notification with date, time, and reason for transfer in a language and manner the resident/family member and/or representative can understand. (3)Systemic Changes The Social Worker/ designee will send written notification of the reasons for the transfer in a language and manner understand to family members and/or representatives prior to planned discharge/transfer, or following an unplanned transfer as required to meet discharge/transfer notification requirements. Administrator will complete a weekly audit x 4 weeks and then monthly x 3 months that all facility initiated discharged or transferred residents had letters sent to the family or representative as per regulations. (4) Monitoring The Executive Director will discuss the audit results with the IDT during the monthly Performance Improvement meeting for three months. The members of the Performance Improvement committee consists of the Executive Director, Director of Nursing, Assistant Director of Nursing, Registered Dietitian, Social Worker, MDS, and Medical Director, they will review the audits to ensure compliance is ongoing and will	

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F 623	Continued From page 4 monthly of a list of the residents that transferred and discharged from the facility and the nursing staff called the responsible party when a resident went to the hospital. Example #2 Resident #36 was admitted to the facility on 7/5/16 and re-admitted on 4/16/18 and 6/5/18 with diagnoses including Heart Failure, Diabetes and Dementia. Review of Resident #36's most recent minimum data set assessment dated 4/30/18 14-day Minimum Data Set Assessment identified Resident #5 as cognitively intact. The resident was unavailable for interview. Review of Resident #36's chart revealed on 4/10/17 he was transferred to the hospital for a change in condition. No written notice of transfer was documented to have been provided to the resident or resident representative. Further review of Resident #36's chart revealed on 5/23/18 he was transferred to the hospital for a change in condition related to altered mental status. No written notice of transfer was documented to have been provided to the resident or resident representative. During an interview with the Admissions Coordinator on 6/13/18 at 2:05PM she stated she did not send a letter to the resident or responsible party upon transfer to the hospital with an	F 623	determine whether there is a need for further audits/in-services.	

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F 623	Continued From page 5	F 623		

explanation of why the resident was transferred. She stated the nursing staff usually called the responsible party to let them know why the resident was going to the hospital.

During an interview with the Administrator on 6/14/18 at 9:16AM he stated a letter was not being sent upon transfer to the resident or responsible party because phone calls were done He stated the facility would begin sending a letter.

During an interview with the Social Worker on 6/14/18 at 9:35AM she stated that she was responsible to send a notice to the Ombudsman monthly of a list of the residents that transferred and discharged from the facility and the nursing staff called the responsible party when a resident went to the hospital.

Example 3

Resident # 70 was admitted to the facility on 3/15/18 and readmitted on 4/9/18 with diagnoses including Cerebral Vascular Accident, Tracheostomy Status and Acute Respiratory Failure.

Review of Resident # 70 most recent admission Minimum Data Set (MDS) completed on 3/22/18 revealed the resident had severe cognitive impairment.

Review of Resident # 70's medical record on 4/2/18 revealed she was transferred to the hospital for elevated temperatures. No written notice of transfer was documented to have been provided to the resident or her resident representative.

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F 623	Continued From page 6 During an interview with the Admissions Coordinator on 6/13/18 at 2:05PM she stated she did not send a letter to the resident or responsible party upon transfer to the hospital with an explanation of why the resident was transferred. She stated the nursing staff usually called the responsible party to let them know why the resident was going to the hospital. During an interview with the Administrator on 6/14/18 at 9:16AM he stated a letter was not being sent upon transfer to the resident or responsible party because phone calls were done. He stated the facility would begin sending a letter. During an interview with the Social Worker on 6/14/18 at 9:35AM she stated that she was responsible to send a notice to the Ombudsman monthly of a list of the residents that transferred and discharged from the facility and the nursing staff called the responsible party when a resident went to the hospital.	F 623		
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.	F 655		7/10/18

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F 655	Continued From page 7 (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 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 observations, record review and staff interviews, the facility failed to develop a baseline care plan that included minimum healthcare information to provide effective, person-centered care for a resident with a Suprapubic catheter, constipation and hydration for 1 of 6 (Resident #	F 655	Confidentiality This plan of correction is the center□s credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute	

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F 655	Continued From page 8 120) residents reviewed for baseline care plans. The findings included: Resident # 120 was admitted to the facility on 5/30/18 from the hospital with diagnoses including Cerebral Palsy, Quadriplegia, Constipation, Glaucoma, Gastrointestinal Reflux Disease and Insomnia. An Admission/5 day Minimum Data Set (MDS) was opened but had not been completed at the time of the survey. Review of Resident # 120 ' s admission Minimum Data Set (MDS) dated 6/7/18 identified her as cognitively intact and required extensive assistance with bed mobility and toilet use. A review of the physicians ' orders for June, 2018 revealed an order for Indwelling Catheter Care. Cleanse with soap and water every shift. A review of the physicians ' orders for June, 2018 revealed an order for Sennoside tablet 8.6 mg. Give 1 tablet by mouth at bedtime related to constipation. A review of physicians ' orders for June, 2018 revealed an order for Miralax Powder. Give 34 gms by mouth one time a day for constipation. A record review on 5/30/18 revealed a 48 hour Interim Care Plan dated 5/30/18 for problems of: Discharge Plans, ADL Decline, Constipation, Indwelling Catheter, Impaired Skin Integrity related to a a Sacral Stage Pressure Ulcer, Nutritional Status, Indwelling catheter, constipation and hydration were not care planned. An interview conducted on 6/14/18 at 9:41 AM	F 655	admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law. (1)Interventions for affected resident: Resident # 120 has been discharged from the facility. Resident had completed baseline care plan with goals and interventions upon discharge. (2)Interventions for residents identified as having potential to be affected: An audit of care plans was completed on residents admitted since 6/14/18 by the MDS Nurse. Current residents have comprehensive care plans including goals and interventions in place. These care plans have been reviewed by the IDT team which includes the Director of Nursing, Assistant Director of Nursing, Social Worker, Activities, Unit Managers, Registered Dietician and MDS Nurse. (3)Systemic Change Upon admission residents will be reviewed at clinical morning meeting to ensure 48 hour baseline care plan has been completed with goals and interventions in place. The IDT team will review each new admit using 48 hour care plan audit tool. The audit tool will be complete five (5) days per week at clinical morning meeting x 4 weeks, then three (3) days per week x 4 weeks and two (2) days per week for 4 weeks then weekly x	

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F 655	Continued From page 9 with the Director of Nursing (DON) revealed she would have been the one to implement the resident's baseline care plan and revealed the catheter, constipation and hydration use got missed for this resident. She remembered they discussed the care plan with the resident but did not write a care plan. In an interview conducted on 6/14/18 at 11:48 AM with the Administrator revealed that his expectation was staff would assess the resident and begin the process for providing resident care.	F 655	4 weeks. In-service will be provided to the IDT team which includes the Director of Nursing, Social Worker, Staff Development Coordinator, Activities, Assistant Director of Nursing, Unit Manager by the Nurse Consultant using the policy and procedure to ensure compliance. New IDT team members will be educated upon hire and with orientation to ensure compliance. (4) Monitoring of the change to sustain system compliance ongoing: The Executive Director will report the audit findings to the QA committee x 4 months. The QA committee which consist of Executive Director, Director of Nursing , MDS, Nurse Managers, SDC, ADON, Activities Coordinator, Social Worker, BOM, Medical Director and Pharmacy Rep. QAP will review the audits and ensure compliance is ongoing and determine the need for further audits.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain	F 656		7/10/18

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F 656	Continued From page 10 or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, observations and resident and staff interviews, the facility failed develop a care plan for 1 of 1 sampled residents reviewed for pain. (Resident #62). The findings included: Resident #62 was originally admitted to the facility on 5/14/18, with diagnoses including Disease of	F 656	Confidentiality This plan of correction is the center□s credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of	

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F 656	Continued From page 11 Bone, Muscle Weakness (generalized) Pathological Fracture and Peripheral Vascular Disease. According to the most recent Admission Minimum Data Set (MDS) dated 5/21/18, Resident #62 had limited bed and transfer mobility. He required extensive assistance in other areas of activities of daily living, such as toileting, bathing and personal hygiene. He required set up for meals. Review of a pain evaluation assessment which was completed on 5/15/18, revealed a pain assessment summary and rationale for a care plan decision. The assessment revealed Resident #62 said his pain was controlled with pain medication as needed. The recommendation was to continue with the plan of care for pain medication as needed. Review of the Care Area Assessment Summary dated 5/21/18 revealed Resident #62 triggered for pain. The assessment noted Resident #62 had "multiple diagnoses that could exacerbate pain such as claudication (pain and/or cramping in the lower leg due to inadequate blood flow to the muscles) in lower extremities, right shoulder (clavicle repair) multiple lytic bone lesions, cancer. The assessment noted Resident #62's pain was managed fair as it related to claudication however, the right foot pain could be severe. The pain medication worked, but the break through pain could be bad." The Care Plan decision noted Y for yes, however, review of Resident #62's care plan revealed he was not care planned for pain. During an interview on 6/11/18 at 11:23 AM, Resident #62 revealed he was getting pain	F 656	deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law. (1)Interventions for affected resident: Resident # 62 had a comprehensive care plan completed for area of pain. The care plan was reviewed by the IDT team members (MDS, Social Worker, Don, Activities Director and Unit Managers). The resident was informed of the changes to the care plan. The MD was notified of the revisions to the care plan made by the IDT team. (2)Interventions for residents identified as having potential to be affected: Current residents in the facility have the potential to be affected. An audit was completed on June 22, 2018, by the Director of Nursing/ designee for current residents having pain and current care plans are in place for each resident. In-service will be provided to the IDT team by Staff Development Coordinator/designee regarding care planning pain on residents that have pain identified. Newly hired members of the IDT team will receive education during orientation regarding care planning pain when identified. (3) Systemic Change Current staff will be educated on July 2 and July 3 by the Staff Development Coordinator/designee to the current IDT team (Director of Nursing, MDS, SOCIAL WORKER, ACTIVITIES COORDINATOR,	

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F 656	Continued From page 12 medication for bone disease and he received the pain medication every 4 hours. During an interview on 6/13/18, the Minimum Data Set (MDS) Nurse #2 revealed Resident #62 triggered for pain and she would proceed to care plan. She stated she did not know the computer system that well and thought she had care planned Resident #62 for pain and she did not save it. She stated she would correct it and keep it going. During an interview on 6/14/18 at 10:44 AM, the Director of Nursing (DON) revealed her expectation regarding care plans was for the resident to be care planned. During an interview on 6/14/18 at 11:17 AM, the Administrator revealed his expectation was that staff assess the resident and care plan the resident.	F 656	and NURSE MANAGERS) related to completion of care plans for residents who trigger for pain. Residents who have pain noted on the care plan will be reviewed at clinical morning meetings Monday thru Friday to ensure care plans are in place. IDT team will perform audits each morning during the clinical morning meeting as follows: three(3) days per week for four weeks then two (2) days per week for four weeks then weekly four weeks. Care plans will also be reviewed at weekly Medicare meetings for a period of twelve weeks. (4) Monitoring of the change to sustain system compliance ongoing: The Executive Director will report the audit findings to the QA committee monthly for 3 months. The QA committee(Executive Director, Director of Nursing , MDS, Nurse Managers, SDC, ADON, Activities Coordinator, Social Worker, BOM, Medical Director and Pharmacy Rep. QAPI will review the audits and ensure compliance is ongoing and determine the need for further audits/ re-education beyond the period of three months.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in	F 684		7/10/18

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F 684	Continued From page 13 accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to administrator a medication according to physician orders for one of one sampled residents (Resident # 120) receiving a glaucoma medication. The findings included: Resident # 120 was admitted to the facility on 5/30/18 from the hospital with diagnoses including Cerebral Palsy, Quadriplegia, Constipation, Glaucoma, Gastrointestinal Reflux Disease and Insomnia. An Admission/5 day Minimum Data Set (MDS) was opened but had not been completed at the time of the survey. Review of Resident # 120 ' s admission Minimum Data Set (MDS) dated 6/7/18 identified her as cognitively intact and required extensive assistance with bed mobility and toilet use. Resident # 120 was transferred and admitted to the hospital on 6/8/18 with a diagnoses of Urinary Tract Infection (UTI). A review of the physician orders from May, 2018 revealed an order for Travoprost solution 0.004 %. Install one drop in both eyes at HS (evening time) related to unspecified glaucoma. Start date 5/30/18. Review of the Medication Administration Record (MAR) for June 2018 documented the Travoprost solution 0.004 %. as given on 6/1/18, 6/4/18, 6/5/18, 6/6/18, and on 6/7/18 the MAR	F 684	F684 Quality of Care CFR(s) 483.25(c)(3)-(6)(8) (1)Resident Affected: Missing glaucoma medication for resident #120 was obtained and administered per orders. Thorough evaluation of medical record and resident assessment completed; it was determined that resident suffered no ill effects. Resident has been discharged from facility with no negative outcome identified. (2)Resident with Potential to be Affected Current residents have the potential to be affected. Audit of all residents□ current medication orders compared to available medications on medication carts will be completed on 7/9/18 by Director of Nursing, ADON, Unit Managers and Staff Development Coordinator; this process is in place to ensure that current medications are available for administration per physician orders. (3)Systemic Changes Director of Nursing/ designee will perform audits of medication carts to verify medications are available and intervene as appropriate to correct any issues identified. Audits will be completed two (2) times per week for 6 weeks then weekly for six (6) weeks, to be reviewed at	

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F 684	Continued From page 14 documented Resident # 120 as in the hospital. In an interview conducted on 6/13/18 at 3:35 PM the nurse assigned to Resident # 120 ' s medication cart third shift on 6/2/18 and 6/3/18 stated if the medication was not in the cart she did not give it. She revealed staff are to call the pharmacy or call and notify the physician of the medication and request how to proceed. She revealed she In an interview conducted on 6/4/18 at 8:51 AM the back hall Unit Manager Nurse revealed pharmacy delivered to the facility Monday thru Saturdays and sometimes would make a delivery on Sunday. She revealed receiving medications were checked in by the nurse on duty and staff were to acknowledge the medication was received in the computer. In an interview on 6/14/18 at 9:41 AM the Director of Nursing (DON) revealed the glaucoma eye medication was in the building. The DON revealed she expected staff to go look for the medication. If the medication was not available, staff were expected to call the pharmacy ask about the medication or call the physician, ask about the medication and ask what to do.	F 684	the clinical morning meeting. In-service will be provided to nursing staff in regards to medication availability by the Director of Nursing. New staff will be educated on this process upon hire during orientation (4)Monitoring The Executive Director will discuss audit results with the IDT during monthly Performance Improvement meetings for a period of three months. The Performance Improvement committee consists of the Executive Director, Director of Nursing, Assistant Director of Nursing, Registered Dietitian, Social Worker, MDS, and Medical Director. The committee will review audits to ensure compliance is ongoing and to determine whether there is a need for further audits/in-services.	
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to maintain the area surrounding the dumpster free of debris for 1 of 1	F 814	Confidentiality This plan of correction is the center□s	7/10/18

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F 814	Continued From page 15 dumpsters observed. The findings included: Review of the Waste Management For Foodservice policy dated 11/28/17, reads as follows: Under 9. "In the dumpster area. A. Confirm lid or door is closed on the dumpster before leaving the area. Do not leave any trash alongside or on top of the dumpster." During an observation of the dumpster with the Certified Dietary Manager on 6/11/18 at 10:38 AM eight disposable gloves and 2 empty cigarette packs were observed on the ground behind the dumpster. During a second observation of the dumpster area on 6/12/18 at 8:26 AM eight disposable gloves and 2 empty cigarette packs were observed on the ground behind the dumpster. A third observation on 6/13/18 at 2:50 PM the dumpster area observed to be in the same condition. In an interview on 6/13/18 at 2:53 PM with the Certified Dietary Manager he revealed housekeeping staff were responsible for keeping the dumpster area. He indicated he would inform them right away the area needed attention. In an interview on 6/14/18 at 9:40 AM the Director of Nursing revealed she expected if staff saw something on the ground they get a glove, pick it up and throw it away and close the dumpster door. In an interview on 6/14/18 at 10:00 AM the Housekeeping/ Laundry Supervisor revealed the	F 814	credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law. 1.)All residents identified as having potential to be affected: All residents in the facility have the potential to be affected. An additional trash pick up was completed by the facility on June 15, 2018. The Maintenance Director and Housekeeping Director will be in-serviced on July 3, 2018 on the Environmental Policy and Procedures by the facility Executive Director. Current staff will also be educated on the Environmental Policy and Procedures on July 3, 2018 by the Executive Director. An audit was completed on June 15, 2018, by the housekeeping manager and the maintenance director to ensure there was not any loose articles around the dumpster area. The audit will continue to be a part of the education process for current staff and newly hired members of the IDT team upon orientation. 2.) Systemic Change Current staff will be in-serviced starting on July 3 by the SDC and Nurse Consultant on the Environmental Policy and Procedures until 100% of staff have been	

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F 814	Continued From page 16 dumpster area had been cleaned up. He revealed now when staff were cleaning up around the smoking area to also clean up around the dumpster.	F 814	in-serviced. The Housekeeping manager will complete daily audits 4 days per week X 4 weeks, then 2 days per week X 4 weeks then 1 day per week for 4 weeks. This process is in place to ensure that there will be no loose articles and/or trash around the dumpster. The Environmental Policy and Procedures will be part of orientation for all new hires. 3.) Monitoring of the change to sustain system compliance ongoing: The Executive Director will report audit findings to the QA committee monthly which consists of ED, DON, ADON, MDS, Medical Director, Social Worker, Admission Coordinator, Culinary Manager, BOM and Activities Coordinator for 3 months. The QA committee will review audits and ensure compliance is ongoing to determine whether there is a need for further audits/ re-education beyond the period of three months.	
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to	F 865		7/10/18

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F 865	Continued From page 17 the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and resident and staff interviews, the facility's Quality Assurance and Performance Improvement committee (QAPI) failed to maintain implemented procedures and monitor these interventions that the committee put into place in July of 2017. This was for one (1) recited deficiency which was originally cited on 7/13/16 (F279) during the recertification survey and on the current recertification/complaint survey on 6/14/18 (F656). The continued failure of the facility during the two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance and Performance Improvement Program. The findings included: This tag is cross referenced to: 1. F656. Based on observations, record reviews and resident and staff interviews, the facility failed to develop a care plan for 1 of 1 sampled residents reviewed for pain. (Resident #62) During the recertification/complaint survey of 7/13/17, the facility was cited F 279 for failure to develop comprehensive plans of care related to the use of antipsychotic medications for 2 of 7 residents reviewed for unnecessary medications	F 865	Confidentiality This plan of correction is the center□s credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law. (1)Interventions for affected resident: Resident # 62 had a comprehensive care plan completed for area of pain. The care plan was reviewed by the IDT team members (MDS, Social Worker, Don, Activities Director and Unit Managers). The pain care plan related to pain was discussed with the resident by the IDT and no changes were identified or needed. The care plan revisions were discussed with the Medical Director by the IDT with no further changes added to the care plan (2) Interventions for residents identified as having potential to be affected:	

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F 865	Continued From page 18 (Residents #58 and #117). During an interview on 6/14/18 at 11:30 AM, the Administrator revealed they identified they were lacking in assessments so they developed assessment protocols and they had them in place to address deficiencies. He stated they are trying to develop more structure to development of care plans and better communication as part of that. He reported that QA meetings addressed any concerns they had in the building and they developed plans and ensured the concerns were corrected. He stated they revised the plan based on monitoring and that is what initiated the plan they have in place now. He revealed the plan was developed by the MDS Coordinator and reviewed in the QA meeting monthly and they ensured they were meeting their plan. He stated the committee ensured that everyone was held accountable. During an interview on 06/14/18 at 12:32 PM, the Minimum Data Set (MDS) Nurse #2 stated as part of the MDS restructure she had a three month Care plan calendar that coordinated with the MDS schedule including any significant changes identified, and completed a corresponding care plan. She revealed they made sure they met all requirements and the entire care plan process was included in the QAPI. She revealed they increased opportunities to care plan to two times a week. She said this was something they were working on.	F 865	A QAPI meeting will be held on 7/5/18 to discuss care plan accuracy by the QAPI committee which consist of ED, DON, MDS, Nurse Managers, SDC, ADON, Activities Coordinator, Social Worker, BOM, Medical Director and Pharmacy Rep. QAPI will review the corrected care plans for accuracy and completeness for pain interventions and goals. (3) Systemic Changes A weekly QAPI meeting will be held for a period of four (4) weeks then Monthly x 2 months to review and discuss the facility adherence to the monitoring of the care plans accuracy. The Director of Nursing / designee will perform audits on the Care Plan process weekly x 4 weeks and then monthly x 2 months to determine the accuracy of the care plans. Education will be provided to the IDT team by SDC and the Nurse Consultant for the resident who have a need for a care plan to cover pain. The audit will continue to be a part of the education process for current staff and newly hired members of the IDT team upon orientation. (4) Monitoring of the change to sustain system compliance ongoing: The Executive Director will report the audit findings to the QA committee monthly for 3 month. The QAPI committee consists of ED, DON, MDS, Nurse Managers, SDC, ADON, Activities Coordinator, Social Worker, BOM, Medical Director and Pharmacy Rep. QAPI to ensure compliance is ongoing and determinate the need for further	

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F 865	Continued From page 19	F 865	audits.	