STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND RETIREMENT	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §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	F 584		7/6/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/29/2018

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F 584	Continued From page 1 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to store a urine catchment container, a bucket for a bedside commode and bath basins off the floor in resident bathrooms (room #107 and #111) on 1 of 5 occupied resident halls. The facility also failed to repair stained or broken tile in resident bathrooms and stains around the base of toilets (room #107, #108, #404 and #407) on 2 of 5 occupied resident halls. Findings included: 1. a. Observations on 06/04/18 at 3:42 PM in the bathroom of resident room #107 revealed a plastic urine catchment container (urine hat) which was uncovered lying on the floor on its side in the bathroom next to the toilet. The observations also revealed the bucket of a bedside commode was sitting on the floor next to the toilet. Observations on 06/05/18 at 3:32 PM in the bathroom of resident room #107 revealed a plastic urine hat which was uncovered lying on the floor on its side in the bathroom next to the toilet. The observations also revealed the bucket of a bedside commode was sitting on the floor next to the toilet. Observations on 06/06/18 11:54 AM in the bathroom of resident room #107 revealed a plastic urine hat which was uncovered lying on the floor on its side in the bathroom next to the toilet. The observations also revealed the bucket of a bedside commode was sitting on the floor	F 584	This Plan of Correction is submitted as required under Federal and State Regulation and statues applicable to long term care providers. This plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the findings constitute a deficiency, or that they scope and severity regarding any of the deficiencies are correctly applied. F 584 1. Urine catchment container (urine hat), bath basins and bedside commode buckets in bathroom of rooms 107 and 111 was removed on 6/8/2018. New containers were placed in bags, labeled and placed off the floor. Tiles and stains in rooms 107, 108, 404, 401 and 407 were evaluated on 6/8/2018 by the Maintenance and Housekeeping Supervisor. Tiles with stains that could not be removed by housekeeping, were replaced by the Maintenance Supervisor on 6/27/18. 2. All residents have the potential to be affected by the alleged deficient practice. A facility audit was completed by the Administrator and Housekeeping	

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F 584	Continued From page 2 next to the toilet. b. Observations on 06/04/18 at 3:50 PM in the bathroom of resident room #111 revealed 2 bath basins which were uncovered on the floor. Observations on 06/05/18 at 9:07 AM in the bathroom of resident room #111 revealed 2 bath basins which were uncovered on the floor. Observations on 06/06/18 at 11:36 AM in the bathroom of resident room #111 revealed 2 bath basins which were uncovered on the floor. During an interview on 06/07/18 at 9:45 AM, Nurse Aide #1 she stated staff were expected to store bath basins and other resident care items in plastic bags and they were not supposed to be stored on the bathroom floors. During an interview on 06/07/18 at 9:46 AM, Nurse #1 stated bath basins and other resident care items should be covered and stored in the area of the residents' choice but they should not be stored on the floor in resident's bathrooms. During a tour and interview on 06/07/18 at 9:54 AM, the Director of Nursing confirmed urine hats, bath basins and buckets for bedside commodes should not be sitting on the floor in resident bathrooms. She stated it was her expectation for resident care items to be labeled and placed in bags and stored off the floor. 2. a. Observations on 06/04/18 at 3:42 PM in the bathroom of resident room #107 revealed black stains in between cracks in the tile on the floor. Observations on 06/05/18 at 3:32 PM in the	F 584	Supervisor - no other Urine catchment containers (urine hats), bath basins and bedside commode buckets were found to be stored out of compliance; additional replacement of some tiles have been completed as a result of the audit. 3. The Director of Nursing re-educated all staff on the proper storage of urine catchment containers, bath basins and bedside commodes. All staff have been re-educated on the process to log a work order for tiles that need replacement. Staff are to complete/log a work order and place in Maintenance Communication book at each nurses station. Maintenance Director/Administrator will check maintenance communication book 5 times weekly. Administrator and DON will follow up daily during Stand Up meeting to ensure continued compliance. 4. The Director of Nursing/ Unit Managers will do audits - for storage of urine catchment containers, bedside commodes and wash basins - 4 times a week for 4 weeks, then 2 times a week for 3 weeks, then weekly for 4 weeks. Assigned Room Ambassadors will conduct weekly audits to identify areas of concern 5 times a week for four weeks, then 2 times a week for 2 weeks and then 1 time a week for 1 month. Maintenance Director and Housekeeping supervisor will address stained or broken	

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F 584	Continued From page 3 bathroom of resident room #107 revealed black stains in between cracks in the tile on the floor. Observations on 06/06/18 11:54 AM in the bathroom of resident room #107 revealed black stains in between cracks in the tile on the floor. b. Observations on 06/04/18 at 3:45 PM in the bathroom of resident room #108 revealed dark brown stains in the grout around the base of the toilet. Observations on 06/05/18 03:36 PM in the bathroom of resident room #108 revealed dark brown stains in the grout around the base of the toilet. Observations on 06/06/18 at 11:53 AM in the bathroom of resident room #108 revealed dark brown stains in the grout around the base of the toilet. c. Observations on 06/04/18 at 3:25 PM in the bathroom of resident room #404 revealed tile on the floor with dark brown stains around the front and behind the toilet and there was an odor of stale urine in the room. Observations on 06/05/18 09:02 AM in the bathroom of resident room #404 revealed tile on the floor with dark brown stains around the front and behind the toilet and there was an odor of stale urine in the room. Observations on 06/06/18 at 4:17 PM in the bathroom of resident room #404 revealed tile on the floor with dark brown stains around the front and behind the toilet.	F 584	tiles as identified during Ambassador audits. Administrator will follow up to ensure timely completion on a daily and weekly basis. Administrator to ensure compliance via verification of audit accuracy. Data obtained during audits will be analyzed for patterns and trends by Administrator. This information will be reported during the Quality Assurance (QAPI)process for 3 months or until new annual survey for continued compliance.	

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F 584	Continued From page 4	F 584		

d. Observations on 06/04/18 03:29 PM in the bathroom of resident room #407 revealed black stains between the tiles on the floor in front of the toilet.

Observations on 06/05/18 at 12:12 PM in the bathroom of resident room #407 revealed black stains between the tiles on the floor in front of the toilet.

Observations on 06/06/18 at 4:21 PM in the bathroom of resident room #407 revealed black stains between the tiles on the floor in front of the toilet.

During a tour and interview on 06/08/18 at 12:54 PM, the Director of Maintenance/ Maintenance Supervisor explained the facility utilized a work order system and the work order slips were kept at each nurse's station. He further explained they also had a maintenance communication notebook at the nurse's stations and staff wrote down repairs that were needed. He stated he preferred for staff to write down the work requests so he could maintain a record of them and to prevent them from being forgotten. He explained when there were stains on resident bathroom floors he left it to housekeeping staff's discretion for cleaning but if they could not get the floor clean they were supposed to report it to maintenance so the tile could be repaired or replaced. He confirmed the tile in front of the toilet in the bathroom of resident room #401 was cracked and needed to be repaired.

During an interview and tour on 06/08/18 at 1:05 PM, the Assistant Manager of Housekeeping stated they could use a scraper to try and remove the stains around toilets but if they could not

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F 584	Continued From page 5 remove the discoloration housekeeping staff was supposed to notify maintenance to replace the tile. She further stated housekeeping staff were also supposed to look for broken or missing tile during routine cleaning and report it to maintenance. During an interview on 06/08/18 at 2:34 PM, Administrator #1 stated it was her expectation for housekeeping staff to keep a list of rooms and things that needed to be addressed similar to the list for repairs maintenance staff kept to complete. She further stated she expected when housekeeping staff cleaned resident bathrooms but could not remove stains they should contact maintenance to address it.	F 584		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code a diagnosis on a Minimum Data Set Assessment for 1 of 1 sampled resident for dialysis (Residents #20). Findings included: Resident #20 was admitted to the facility on 06/01/16 with diagnoses which included in part kidney disease and hemiplegia (paralysis) and hemiparesis (weakness) following unspecified cerebrovascular disease (stroke) affecting unspecified side.	F 641	This plan of correction is submitted as required under Federal and State Regulation and statues applicable to long term care providers. This plan of correction does not constitute an agreement by the facility and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are	7/6/18

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F 641	Continued From page 6 A review of Resident #20's most recent Minimum Data Set (MDS) dated 04/04/18 and coded as a quarterly assessment revealed Resident #20 was cognitively impaired for daily decision making. The MDS also revealed Resident #20 was coded as requiring total assistance with transfer and bathing and required extensive assistance with personal hygiene, toilet use, dressing, locomotion on and off the unit and bed mobility. Further review of Resident #20's MDS revealed she was coded as "no" for cerebrovascular accident (CVA), transient ischemic attack (TIA), or stroke. During an interview with Physician Assistant #1 on 06/08/18 at 9:28 AM it was revealed that a diagnosis of "hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting unspecified side and unspecified sequelae of other cerebrovascular disease" meant Resident #20 dealt with a lack of movement and/or weakness due to a cerebrovascular incident (a stroke or stroke like incident). An interview with MDS Nurse #1 on 06/08/18 at 2:11 PM revealed she should have coded a "yes" for a cerebrovascular accident on Resident #20's quarterly MDS dated 04/04/18. She reported she must have "just overlooked" the diagnosis related to cerebrovascular accident due to Resident #20's extensive other diagnoses. During an interview with the Director of Nursing on 06/08/18 at 3:05 PM she reported it was her expectation that diagnoses should be coded in the MDS assessment correctly. An interview with the Administrator on 06/08/18 revealed it was her expectation that MDS	F 641	correctly applied. 1. All Residents have the potential to be affected by the alleged deficient practice. The RCMD or designee will complete an audit of all current residents receiving OBRA assessment during the last 14 days to verify accurate coding of Section I of the MDS per the RAI manual Guidelines. 2. Resident #20 will require a correction for the Quarterly Assessment ARD 4/4/18 to reflect accurate coding in Section I in the MDS. The ARD for the Modification for this assessment is 4/23/18. A Modification was completed by the RCMD and or designee per the RAI manual guidelines. 3. The District Director of Care Management will re-educate the MDS staff on accurate coding related to Diagnosis in Section I on 6/28/18. 4.The District Director of Care Management/ Administrator will randomly review 5 completed MDSs weekly for 12 weeks to verify accurate coding of Section I of the MDS. Opportunities will be corrected as identified as a result of these audits. The results of the audits will be presented by the Resident Care Management Director monthly for 3 months at Facility QAPI meeting. The committee will make changes or recommendations as indicated.Administrator to ensure compliance via verification of audit accuracy.	

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F 641	Continued From page 7 assessments were completed accurately and she expected diagnoses to be reviewed and verified through the medical record.	F 641		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight	F 842		7/6/18

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F 842	Continued From page 8 activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to document nursing progress notes or assessments after a resident had a change in condition prior to transfer to a hospital (Resident #63) for 1 of 2 residents sampled for urinary tract infections and failed to document the date and	F 842	This plan of correction is submitted as required under Federal and State Regulation and statues applicable to long term care providers. This plan of correction does not constitute an agreement by the facility and such liability	

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F 842	Continued From page 9 time on a hand written physician's order for 1 of 5 residents sampled for unnecessary medication review. Findings included: 1. Resident #63 was admitted to the facility on 12/14/16 with diagnoses which included heart failure, generalized muscle weakness, adult failure to thrive, anemia and dementia. A review of the most recent quarterly Minimum Data Set (MDS) dated 05/23/18 indicated Resident #63 was severely impaired in cognition for daily decision making. The MDS also indicated Resident #63 required extensive assistance for activities of daily living except he was independent with eating. A review of a change in condition form titled Situation, Background, Assessment/Appearance and Recommendation (SBAR) dated 06/05/18 at 6:52 PM completed by Nurse #2 indicated Resident #63 was different than usual and it had been noted over the last few days. The document further indicated Resident #63 was refusing medication and was not eating meals. The document revealed Resident #63 was talking but was communicating less and appeared weak, confused and drowsy and the responsible party and physician were notified on 06/05/18. A review of nurse's progress notes dated 06/06/18 at 3:25 PM documented by the Unit Manager revealed results of a chest x-ray and complete blood count were reported to the Nurse Practitioner (NP) and orders were received to give Rocephin (antibiotic) for 7 days.	F 842	is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are correctly applied. 1. On 06/07/2018 Nurse #1 failed to document change in condition/assessment in progress notes for Resident #63 before transfer to hospital. Unit Manager entered documentation for change in condition/assessment for Resident #63. Physician order for Resident #4 to discontinue Magnesium Oxide and to obtain a magnesium level was clarified with Physician to include a date and time. 2. All residents residing in the facility have the potential to be affected. Facility audit conducted on 6/29/2018 by the DON and Nursing Management, revealed no new areas of concern. Nurse #1, no longer employed by the facility. 3. Licensed Nurses to be re-educated by the DON/Nursing Management or designee on documentation of change of condition, document in nursing progress notes or assessments and documentation of physician orders. Unit Manager re-educated on the importance of follow up related to SBARs and Change of Condition documentation during Clinical Start Up Meeting by Director of Nursing.	

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F 842	Continued From page 10 A review of nurse's progress notes dated 06/06/18 at 11:50 PM documented by Nurse #2 revealed Resident #63 appeared weak and had poor oral intake on second shift. The notes further revealed Resident #63 had no fever but a wet cough was noted and tea colored urine was obtained for a urinalysis. A further review of Resident #63's medical record revealed there were no nurse's progress notes or assessments documented on 06/07/18. A review of a physician's order dated 06/07/18 indicated to transfer Resident #63 to the emergency room for further evaluation. During an interview on 06/08/18 at 1:14 PM, the Unit Manager with the Corporate Staff Development Manager present explained the SBAR for Resident #63 had been reported to her on 06/06/18. She explained she notified the NP who ordered for a chest x-ray and complete blood count to be done. She further explained when the chest x-ray and lab results came back she called the NP to report Resident #63 had infiltrates (fluid in his lungs) and an increased white blood cell count. She stated the NP ordered Rocephin to be given for 7 days and the responsible party was notified. She explained on 06/07/18 Nurse #1 reported to her that Resident #63 needed further evaluation because of increased fluid in his lungs. The Unit Manager confirmed there were no nursing progress notes or nursing assessments documented after 06/06/18 at 11:50 PM. She stated it was her expectation for there to have been a progress note or nursing assessment written by a nurse during the night shift on 06/07/18 regarding the condition of Resident #63. She stated she would	F 842	Physician re-educated by the DON on 6/23/2018, related to dating and timing physician orders. Medical Records clerk will be re-educated on the process for reviewing charts to identify order without physician signature, date or time. All education will be completed by 7/6/2018. 4. DON/ Unit Managers will audit 5 random resident weekly for 12 weeks during Clinical Start Up meeting, to ensure documentation of change of condition, progress notes or assessments and physician orders. Data collected from the audits will be reviewed by the QAPI committee to identify any trends. Information will be tracked for 3 months by the QAPI committee to ensure continued compliance. Administrator to ensure compliance via verification of audit accuracy.	

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F 842	Continued From page 11	F 842		

have expected to see documentation of lung sounds, vital signs or whatever pertained to the concerns of Resident #63.

During an interview on 06/08/18 at 1:20 PM the Corporate Staff Development Manager explained it was her expectation for an SBAR to be completed for changes in condition. She stated there should also be an assessment of the resident after the SBAR and the documentation should be related to whatever the condition was identified on the SBAR.

During an interview on 06/08/18 at 2:32 PM, Administrator #1 stated it was her expectation for nurses to document any changes in condition or follow up notes. She further stated if a nurse had not documented follow up notes or assessments then she would expect for the nurse to be called to document an assessment of the resident.

During a telephone interview on 06/08/18 at 2:44 PM, Nurse #1 confirmed she assessed Resident #63 after 7:00 AM on 06/07/18 and he had increased fluid in his lungs. She explained she reported it to the Unit Manager and Resident #63 was sent to the hospital for evaluation and treatment. She stated she would have expected to see some nurse's notes as to Resident #63's condition during the night shift on 06/07/18. She further stated nurses were expected to document assessments or the condition of the resident in the nurse's progress notes.

During an interview on 06/08/18 at 3:08 PM, the Director of Nursing stated it was her expectation for nurses to document a progress note regarding the resident's change in condition. She further stated when a resident had a change in condition

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they should document on the SBAR and then should document an assessment every shift after the SBAR.

2. Resident #4 was re-admitted to the facility on 01/8/16 with diagnoses which included high blood pressure, kidney disease, anxiety, dementia, depression, generalized weakness and history of a stroke.

A review of the most recent annual Minimum Data Set (MDS) dated 03/02/18 revealed Resident #4 was moderately impaired in cognition for daily decision making. The MDS also indicated Resident #4 required extensive assistance with activities of daily living except she required supervision with eating.

A review of a hand written physician's order indicated to discontinue Magnesium Oxide and obtain a magnesium level but there was no date or time on the order.

During an interview on 06/08/18 at 1:09 PM, the Unit Manager explained hand written physician orders usually had the resident name, date, time and if it was a telephone order or verbal order and the nurse's signature.

During an interview on 06/08/18 at 3:08 PM, the Director of Nursing stated it was her expectation for the date and time to be documented on the hand written physician's orders.

During an interview on 06/08/18 at 3:45 PM, the Corporate Nurse Consultant verified the hand written physician's order for Resident #4 to discontinue Magnesium Oxide and obtain a magnesium level had been documented by the

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F 842	Continued From page 13 Nurse Practitioner (NP) but did not indicate the date and time of the order. She stated it was her expectation for nurse's to check physician and NP orders to ensure the orders were dated and timed.	F 842		
F 865 SS=E	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place following the recertification survey of 0714/17. This was for one recited deficiency that was originally cited during the annual recertification survey of 10/02/15, was cited again during the annual recertification and complaint survey of	F 865	This plan of correction is submitted as required under Federal and State Regulation and statues applicable to long term care providers. This plan of correction does not constitute an agreement by the facility and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyors' findings or conclusions are	7/6/18

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F 865	Continued From page 14 11/03/16, was subsequently recited again during the annual recertification and complaint survey of 07/14/17 and was recited again on the annual recertification survey of 06/08/18. This repeat deficiency was in the area of housekeeping and maintenance services. A second deficiency was originally cited during the recertification and complaint survey of 07/14/17 and was cited again during the current recertification survey of 06/08/18. This repeat deficiency was in the area of resident records. The continued failure of the facility during four federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program. The Findings Included: The tag is cross referred to: 1. F-584 Safe, clean, comfortable and homelike environment: Based on observations and staff interviews the facility failed to store a urine catchment container, a bucket for a bedside commode and bath basins off the floor in resident bathrooms (room #107 and #111) on 1 of 5 occupied resident halls. The facility also failed to repair stained or broken tile in resident bathrooms and stains around the base of toilets (room #107, #108, #404 and #407) on 2 of 5 occupied resident halls. During the Recertification survey completed on 07/14/17, the facility failed to repair broken and splintered laminate on resident room doors and a bathroom door on 3 of 12 resident rooms and 1 of 1 common bathroom doors (Rooms 205, 401, 408 and bathroom on the 300 hall), failed to repair broken floor tile in 1 of 12 resident rooms (room 100), failed to repair patches on wall in 4 of	F 865	accurate, that the findings constitute a deficiency, or that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are correctly applied. 1. Quality Assurance Performance Improvement committee, lead by Administrator, was held on 6/25/2018 to discuss current survey citations and repeat citations to include F584, F641, F842, and F865. Facility Medical Director was part of the committee and aware of the citations and need for continued compliance. 2. Current resident residing in the facility have the potential to be affected. 3. The Divisional Clinical Director or Division Director of Operations re-educated the Interdisciplinary Team to include all department managers and the Administrator of the QA and improvement process- specifically regarding the importance of systematic and consistent approach to applying systems and follow up/follow through for deficiencies F 584 & F 842. Performance Improvement plans will be put in place for Resident Records and Safe/Clean/Comfortable/Homelike Environment. The QIO has been contacted and will set up additional education for the facility related to the Quality Assurance process on 7/13/18 4. Administrator/ DON will verify information collected in audits weekly for 1 month and then monthly for 2 months.	

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F 865	Continued From page 15 12 resident rooms (rooms 200, 202, 206 and 404) and failed to repair water damage on the ceiling in 1 of 12 resident rooms (room 104). During the Recertification survey completed on 11/03/16, the facility failed to label a urinal and a fracture bed pan in 2 resident bathrooms (Rooms 106 and 310) on 2 of 7 resident hallways, failed to repair 13 resident doors (Resident Rooms #103, #201, #205, #207, #305, #310, #311, #401, #405, #512, #601, #700 and #706) with broken and splintered laminate and wood on the edges of the bottom half of the doors (100, 200, 300, 400, 500, 600, and 700 halls), failed to repair 1 of 2 doors to the recreation room with broken and splintered laminate on the lower edges of the door (100 hallway), failed to repair a set of smoke prevention doors (700 hall) with broken and splintered laminate on the lower edges of the doors on 1 of 7 hallways and failed to repair a wall behind a resident's bed with deep gouges into the sheetrock (Room #410-A) on 1 of 7 resident hallways. During the Recertification survey completed on 10/02/15 the facility failed to change a privacy curtain stained with blood for 1 of 1 stained curtains (Resident #128). 2. F-842 Resident records: Based on record reviews and staff interviews the facility failed to document nursing progress notes or assessments after a resident had a change in condition prior to transfer to a hospital (Resident #63) for 1 of 2 residents sampled for urinary tract infections and failed to document the date and time on a hand written physician's order for 1 of 5 residents sampled for unnecessary medication review.	F 865	Administrator to ensure compliance via verification of audit accuracy.Data collected from the audits will be reviewed by the QAPI committee for further recommendations. AdHoc QA meetings will be conducted at the discretion of the Administrator/ Divisional Director of Clinical Services to revise Performance Improvement Plans or implement new plans of action. The Interdisciplinary Team will be required to attend AdHoc meetings, any training related to new PIPs or Action Plans and to acknowledge and accept their responsibilities.	

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F 865	Continued From page 16 During the recertification and complaint survey completed on 07/14/17 the facility failed to document functionality of a bed alarm for a resident at risk for falls (Resident #93), failed to document the correct location of redness or measurements on a resident's heel or whether drainage was present (Resident #69) and failed to document falls for a resident at risk for falls (Resident #122) for 3 of 6 sampled residents for falls and pressure ulcers. During an interview on 06/08/18 at 3:36 PM the Administrator explained the Quality Assessment and Assurance Committee meetings were conducted on a monthly basis which included the Administrator, Director of Nursing, and various department managers. She reported the facility's pharmacist and medical director attended the meetings at least quarterly. She explained the results of the current survey would be reviewed and plans would be developed and implemented to prevent the deficiencies from reoccurring on additional surveys.	F 865		