STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345177	A. BUILDING _____ B. WING _____	C 06/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SVCS PINEHURST	205 RATTLESNAKE TRAIL PINEHURST, NC 28374

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F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff and resident interview, it was determined that the facility failed to protect 1 of 1 resident (#4) from the unwanted advances of another resident (#3). The facility also failed to maintain resident's dignity by exposing the urinary catheter bag in public and by allowing a resident watched the roommate while eating during meals for 2 of 3 sampled residents reviewed for dignity (Residents # 13 & #12). Findings included: 1. Resident #4 was admitted to the facility on 1/6/12 with diagnosis including arteriosclerotic heart disease, generalized anxiety disorder, diabetes, muscle weakness, other secondary Parkinsonism and hypertension. Review of the minimum data assessment 3/12/18 revealed that the resident was alert and oriented with no long or short or long-term memory problems. Resident #3 was admitted to the facility on 5/30/2014 with diagnosis including arteriosclerotic heart disease, hypertension, and unspecified dementia without behavioral disturbance, anxiety	F 557	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the facility has taken or will take actions set forth in this plan of correction. The following plan of correction constitutes the facilities allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date indicated. F557 - Respect, Dignity/Right to have personal property 1.) It is the practice of this facility to treat residents with respect and dignity and to ensure residents' right to retain and use personal possessions. This facility will maintain residents' dignity and respect by; 1) protecting residents from unwanted advances of other residents; 2) covering urinary catheter bags from public view and 3) ensuring residents receive their meals at the same time as their roommate. On 7/3/18, the Interdisciplinary Team	7/12/18

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

Electronically Signed | 07/09/2018

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F 557	Continued From page 1 and depression. Review of the minimum data set assessment completed 6/8/18 revealed the resident scored a 15 on the brief interview of mental status indicating that she had no cognition, long or short term memory problems. The resident was coded as having no signs or symptoms of delirium, behaviors or psychosis. Review of a resident concern form dated as being received 3/20/18 revealed, "Resident stated that she doesn't want other resident to kiss her in the mouth when she visits her. Resident stressed that she didn't want resident to know that she complained about it and did want to hurt other resident's feelings." The resolution on the concern form stated, "Spoke with resident #3 regarding kissing in the mouth and possibility of transmitting flu like bacteria. She understood. Resident #4 is satisfied with the resolution. The form was signed 3/26/18. Social services note 3/26/18 stated that the resident reported a fellow resident was becoming too friendly with her. Review of social service note 4/6/18 revealed that Resident #4 told the social service director (SSD) that a fellow resident had made an inappropriate gesture toward her the night before last. She asked if the SSD would speak with the other resident. The SSD and the DON (Director of Nurses) spoke with fellow resident. SSD follow-up with resident by saying fellow resident will be monitored, her family is taking her out for the weekend and conferencing by the SSD and DON was initiated. Social services was contacted and followed up with an interview at the facility this evening as well. Resident stated she felt safe with the plans in place and that staff was reacting accordingly.	F 557	(IDT) consisting of the Administrator, Director of Nursing, MDS coordinator, Social Worker, Director of Rehab, Dietary Manager, Scheduler, Business office manager and the Activities Director held a Quality Assurance Performance Improvement (QAPI) meeting to discuss the findings of the deficiencies and conduct a root cause analysis for plan of correction. It was determined that the facility did not follow their guidelines for behavior monitoring, foley catheter dignity bags and meal delivery service to ensure residents' dignity and respect was maintained. Resident #4 has not had any further unwanted advances from resident #3 and verbalizes feeling safe and secure in her environment. Resident #3 remains on 1:1 observation until further orders by the physician and continues to be under the care of psych services, without evidence of desires to have unwanted physical contact with resident #4 nor any other residents in the facility. On 7/3/18, the licensed nurse completed an updated behavioral assessment on Resident #3 and #4 with no additional concerns noted. The facility will protect residents from similar situations by monitoring and reporting behaviors of unwanted advances towards other residents immediately. Train 100% of staff on identifying and reporting occurrences of inappropriate touching to their supervisor. Staff will observe cognitively impaired residents for signs of inappropriate or unwanted advances.	

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F 557	Continued From page 2 Interview with Resident #3 on 6.15.18 at 2:50 PM revealed that she kissed Resident #4 goodnight; she gestured toward her forehead and her cheek. She stated that if Resident #4 was uncomfortable she should have been woman enough to stay stop. She stated that Resident #4 welcomed her into her room. She further stated that she goes to see another resident down the hall who is happy to see her because she's alone. Interview with Resident #4 on 6.15.18 at 3:02 PM revealed that a fellow resident came into her room and kissed her goodnight in the mouth every night. She stated that she thought the resident would quit. She tried to turn her head but the resident kissed her in the mouth anyway. Resident #4 reported that the resident came to her room every night. If she was in the bed she would bend down and kiss her in the mouth and tell her that she loved her before going to her room. Resident #4 said she did not tell the resident to stop because she did not want to be ugly. She stated the other resident did it many times for a couple of months. She stated that she told a nursing assistant first and then she went to the social worker who helped her. The resident said that the kissing continued for a couple of weeks after she first told staff. She said that Resident #3 has not returned to her room since she spoke with the social worker. She stated that she wanted staff to help her get to the place where the other resident would not kiss her in the mouth. Interview with the SSD on 6.15.17 at 4:15 PM revealed that after the first report she spoke with the other resident and told her that Resident #4 was not comfortable with her kissing her in the mouth and the resident said she would stop. Per	F 557	Resident #13 no longer resides at the facility. Resident #12 and his roommate will continue to be served at the same time when both are dining in their room to maintain dignity and respect. Resident #13 no longer resides at the facility. 2.) On date July 6th 2018, the Administrator completed an audit of alert and oriented residents by questionnaire to ensure residents were free from unwanted advances of other residents. No adverse findings were reported. On 7/09/18, the DON completed an audit to current facility staff by questionnaire to ensure cognitively impaired residents have not been observed being touched in an inappropriate manner. No adverse findings were observed. Facility staff will complete audit prior to their next scheduled shift. On date 7/4/2018, the Director of Nursing completed an audit of residents with foley catheters to ensure placement of a dignity bag. No adverse findings observed. Dignity bags will continue to be in place for residents with foley catheters to protect from public view and maintain dignity. On date 7/4/2018, Quality Assurance consultant completed an audit of residents who dine in-room with a roommate to correlate meal delivery times with the kitchen and to ensure residents are served meals at the same time to	

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F 557	Continued From page 3 the SSD the resident voiced understanding that there was to be no kissing in the mouth and that she was going to leave Resident #1 alone. The SSD stated that she was called down to Resident #4's room after the incident occurring on 4.6.18 because the resident was crying and wanted to talk to her. She said that Resident #4 wanted Resident #3 to stop kissing her but she did not. The SSD stated that they (the facility) went through all the steps, psych services visited Resident #3, the nursing staff were told to be highly aware and Resident #4 was told to ring the call bell immediately if the other resident entered her room. The SSD stated that the facility provided 1:1 staff for Resident #3 after the second incident and moved her roommate to another room for safety. 2. Resident #13 was admitted to the facility on 6/7/18 with multiple diagnoses including urinary retention. Resident #13 had a physician's order dated 6/7/18 for a urinary catheter due to urinary retention. The nurse's notes dated 6/8/18 at 1:31 AM and 6/10/18 at 9:23 AM indicated that Resident #13 was oriented to person only. On 6/14/18 at 12:50 PM and on 6/15/18 at 9:42 AM, Resident #13 was observed in bed. Her entrance door was open and her urinary catheter bag was visible on the hallway. On 6/15/18 at 9:45 AM, Nurse #3 was interviewed. She stated that she was assigned to Resident #13. Nurse #3 indicated that she did not know why the resident's urinary bag was not in a privacy bag. On 6/15/18 at 12:30 PM, the Director of Nursing (DON) was interviewed. She stated that she	F 557	maintain dignity and respect. No adverse findings observed. 3.) On 7/09/18, the Director of Nursing completed education to facility staff on F557 and maintaining residents' dignity and respect and their right to personal property. Education included identifying signs of unwanted advances of residents and protecting residents by reporting any findings to the Director of Nursing immediately for further investigation; maintaining residents' dignity by providing dignity bags for residents with foley catheters; and ensuring residents who dine in a common area are served together. All staff will be educated prior to working their next scheduled shift or upon hire. On 7/03/2018 the Dietary Manager provided additional education to the dietary staff on the revised tray delivery schedule to ensure residents are served together. Newly hired dietary staff will be educated upon hire or prior working their next scheduled shift. The Social Worker will be responsible for completing a Psychosocial Assessment on residents upon admission, readmission and with a change in residents condition. Abnormal findings or reports of unwanted behaviors of others will be reported to the Director of Nursing for further investigation and intervention as appropriate and as ordered by the physician.	

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F 557	Continued From page 4 expected all urinary catheters bags to be in a privacy bag for dignity purposes. 3. Resident #12 was admitted to the facility on 9/11/17 with multiple diagnoses including paraplegia. The quarterly Minimum Data Set (MDS) assessment dated 5/6/18 indicated that Resident #12's cognition was intact and he needed extensive assistance with eating. On 6/15/18 at 11:50 AM, a lunch meal observation was conducted. Resident #12 and his roommate were in the room for lunch. At 12:20 PM, the lunch tray of Resident #12's roommate was served and he started eating. Resident #12 was observed up in his chair in the room watching the roommate having lunch. At 12:50 PM, Nursing Assistant (NA) #2 was observed to serve Resident #12's lunch tray and started feeding him. Resident #12's roommate was already finished eating his lunch when Resident #12's tray was served. On 6/14/18 at 1:30 PM, NA #2 was interviewed. She stated that they have to serve first the trays of residents who were able to feed themselves. The trays of those residents who needed assistance with eating were served last. NA #2 indicated that there were only two NAs assigned on the hall and it took time to pass all the trays. On 6/15/18 at 9:00 AM, a breakfast meal observation was conducted. Resident #12 and his roommate were in the room for breakfast. At 9:00 AM, the breakfast tray of Resident #12's roommate was served and he started eating. Resident #12 was in the room watching the roommate eating his breakfast. At 9:20 AM, Nursing Assistant (NA) #4 was observed to serve	F 557	The licensed nurse will be responsible for ensuring placement of a dignity bag for residents with foley catheters. The nurse aide will observe residents with foley catheters for continued placement of a dignity bag and report concerns to the licensed nurse as needed. The dietary staff will be responsible for preparing meal delivery carts according to room assignments and revised schedule and residents requiring staff assistance with eating will be coordinated to ensure in-room dining at the same time as their roommate to ensure residents' dignity is maintained. 4.) The IDT consisting of the Administrator, Director of Nursing, MDS coordinator, Social Worker, Director of Rehab, Dietary Manager, Scheduler, Business office manager and the Activities Director will complete audits of 1) 5 random residents by questionnaire to ensure freedom from unwanted advances of others and of 2) residents with foley catheters to ensure placement of a dignity bag and of 3) 5 random residents to ensure meal service at the same time. Audits to complete at a frequency of twice weekly for 4 weeks, then weekly for 8 weeks. The QAPI committee will meet at a minimum of monthly to review the results of the audit findings, evaluate the effectiveness of the monitoring and make changes to the plan as appropriate to ensure the continued respect and dignity of residents.	

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F 557	Continued From page 5 Resident #12's breakfast tray and started feeding him. Resident #12's roommate was already finished eating his breakfast when Resident #12's tray was served. On 6/15/18 at 9:50 AM, Resident #12 was interviewed. He stated that he would like his tray served at the same time with his roommate. On 6/15/18 at 12:30 PM, the Director of Nursing (DON) was interviewed. She stated that she expected the staff to serve the trays of residents in the same room at the same time.	F 557	5.) The Administrator is responsible for the implementation and execution of this plan. 6.) Completed by: 7/09/18	
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response.	F 565		7/12/18

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F 565	Continued From page 6 (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review, the facility failed to act on or address grievances of the resident council for 3 (January 2018 through May 2018) out of 5 months of the resident council meeting minutes reviewed. The findings included: Review of the facility policy titled "Patient Concerns" dated June 2016 read the staff were to listen to concerns expressed by residents and initiate the patient concern form. The department receiving the concern were to act timely and initiate the problem-solving process. Resolution was to be documented on the concern form and communicate the person with the concern. Review of the Resident Council minutes for dated 1/24/18 indicated dietary concerns with cold food. Review of the facility grievance list for January 2018 included no grievance involving the report of cold food voiced by the Resident Council. Review of the Resident Council minutes for dated 2/28/18 indicated no dietary concerns with cold food.	F 565	F565- Resident/Family Group and Response 1.) It is the practice of this facility to address, document and provide timely written resolution of grievances of the resident council. On 7/3/18, the Interdisciplinary Team (IDT) held a Quality Assurance Performance Improvement (QAPI) meeting to discuss the findings of the deficiencies and conduct a root cause analysis for plan of correction. The IDT members present included the Administrator, DON, Dietary Manager, Activities Director, Social Worker, Quality Assurance Consultant, MDS, Therapy Manager, Maintenance Director, Housekeeping Manager and Registered Dietitian. It was determined that the facility did not follow their guidelines on the process of addressing resident council grievances. On July 6, 2018 a Resident Council meeting was held with written resolution provided to the resident council president	

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F 565	Continued From page 7 Review of the Resident Council minutes for dated 3/28/18 indicated dietary concerns with cold food. Review of the facility grievance list for March 2018 included one grievance involving the report of cold food voiced by the Resident Council. Review of the Concern Form dated 3/28/18 read as follows: "Resident concerns that the food was not hot. The Resolution of the concern read: "Unable to attend meeting due to a care plan meeting. The Resolution was signed by the Dietary Manager (DM). Review of the Resident Council minutes for dated 4/25/18 indicated dietary concerns with cold food. Review of the facility grievance list for April 2018 included one grievance involving the report of cold food voiced by the Resident Council. Review of the Concern Form dated 4/25/18 read as follows: "Resident said that food still cold." The Resolution of the Concern read: "Plate and base water are now being used. The form was signed by the DM and dated 5/1/18 with no evidence of Administrator review of follow up to the Resident Council. Review of the Resident Council minutes for dated 5/30/18 indicated dietary concerns with cold food. Review of the facility grievance list for May 2018 included no grievance involving the report of cold food voiced by the Resident Council. In an interview on 6/14/18 at 4:30 PM the DM stated she found out 6/14/18 that she was not properly responding for resident grievances. She stated she recently attended a Resident Council meeting and the residents reported improvement with cold food. The DM stated the plate and base plate warmer was broken and replaced earlier	F 565	related to the June 2018 dietary grievance related to cold food temperatures. The plate warmer was repaired and will continue to be used to maintain food temperatures for delivery. The Dietary Manager has also revised the meal delivery schedule to further aid in the timeliness and coordination of warm meals. The resident council verbalized satisfaction with the plan and no further reports of cold food have been made. The resident counsel president was given a written resolution on July 9th, 2018. 2.) On 7/6/2018, the Administrator updated the grievance log. Copies of all grievances will be kept in a binder per guidelines. 3.) On 7/3/18, the Quality Assurance Consultant provided education to department managers on the process of addressing and recording resident council grievances. On 7/3/18, the Administrator provided additional education to the Activity Director identifying, addressing and recording of resident council grievances. Newly hired department managers will be educated upon hire. The Activity Director will be responsible for capturing Resident Council grievances, completing a Concern form, recording concern in meeting minutes and timely presentation to the Grievance Coordinator. The Grievance Coordinator will then be responsible for logging on the Grievance Log and assigning the concern to the appropriate department head for timely investigation and resolution. The	

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F 565	Continued From page 8 this year. She stated it took a while for the corporate office to replace the warmer but it was finally replaced sometime in March 2018. The DM also stated there had been a lot of dietary staff turn-over and the had spoken with the Director of Nursing to ensure the trays were passed timely once they reached the halls. In an interview on 6/15/18 at 7:37 AM, the Resident Council President (Resident #4) stated the food continues to be served cold in her room and in the dining room. She stated the Resident Council had discussed the cold food but there had been no follow up with the group. In an interview on 6/15/18 at 7:50 AM, the Activity Director (AD) stated she had been working at the facility for two months and she completed the grievance dated 4/25/18 regarding the cold food on behalf of the Resident Council. The stated the other months in question were attended by her Activities Assistant (AA). She stated there had not been a June 2018 meeting yet. In an interview on 6/15/18 at 9:20 AM, the AA stated she was aware she should write a Concern Form anytime the Resident Council voices a concern but she simply "forgot" to complete a form in the meeting regarding the cold food. In an interview on 6/15/18 at 12:00 PM, the Administrator stated all grievances should be addressed when presented in the Resident Council or individually. She further stated it was her expectation that there be written follow up to the person or group voicing the concern.	F 565	resolution will then be recorded with written resolution provided to the resident council. The original completed grievance will be maintained by the Grievance Council for a minimum of three years per guidelines. 4.) The Business office Manager will complete audits of resident council minutes for appropriate follow up and record keeping. Audits to be completed at a frequency of weekly for 4 weeks, then monthly for 2 months. The QAPI committee will meet at a minimum of monthly to review the results of the audit findings, evaluate the effectiveness of the monitoring and make changes to the plan as appropriate to ensure the continued resolution of resident council grievances. 5.) The Administrator is responsible for the implementation and execution of this plan. 6.) Completion Date: 7/09/18	
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4)	F 585		7/9/18

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F 585	Continued From page 9 §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for	F 585		

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F 585	Continued From page 10	F 585		

completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be

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	345177	A. BUILDING _____ B. WING _____	C 06/15/2018

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F 585	Continued From page 11 taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to act on or address resident grievances about cold food for 2 (April 2018 and May 2018) out of 4 months of the resident grievances reviewed. The facility also failed to record a grievance and failed to provide a written grievance summary to 1 of 1 sampled resident reviewed for grievance (Resident #2). The findings included: 1. Review of the facility policy titled "Patient Concerns" dated June 2016 read the staff were to listen to concerns expressed by residents and initiate the patient concern form. The department receiving the concern were to act timely and initiate the problem-solving process. Resolution was to be documented on the concern form and communicate the person with the concern. Review of the facility Grievance list revealed a Concern Form dated 4/30/18 which read a resident reported cold breakfast. The Resolution read: "employee counseled." The form was	F 585	F585- Grievances 1.) It is the practice of this facility to address, document and provide timely written resolution of resident grievances. On 7/3/18, the Interdisciplinary Team (IDT) held a Quality Assurance Performance Improvement (QAPI) meeting to discuss the findings of the deficiencies and conduct a root cause analysis for plan of correction. The IDT members present included the Administrator, DON, Dietary Manager, Activities Director, Social Worker, Quality Assurance Consultant, MDS, Therapy Manager, Maintenance Director, Housekeeping Manager and Registered Dietitian. It was determined that the facility did not follow their guidelines on the process of addressing resident grievances. On July 6, 2018 a Resident Council meeting was held with written resolution provided to the resident council president	

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F 585	Continued From page 12 signed by the Dietary Manager (DM) 5/4/18. There was no evidence of review by the Administrator or follow up with the reporting resident. Review of the facility Grievance list revealed a Concern Form dated 5/9/18 which read a resident reported the food was not served at the proper temperature. The Resolution indicated the DM spoke with the resident but there was no mention of the resident concerns related to the food not being served at the proper temperature. The form was signed by the Dietary Manager (DM) 5/9/18. There was no evidence of review by the Administrator or follow up with the reporting resident. Review of the facility Grievance list revealed a Concern Form dated 5/29/18 which read a resident reported the food was cold. The Resolution indicated the DM re-educated the staff on an unrelated food concern. There was not mention of the cold food. The form was signed by the Dietary Manager (DM) 5/29/18. There was no evidence of review by the Administrator or follow up with the reporting resident. In an interview on 6/14/18 at 4:30 PM the DM stated she found out 6/14/18 that she was not properly responding for resident grievances. The DM stated the plate and base plate warmer was broken and replaced earlier this year. She stated it took a while for the corporate office to replace the warmer but it was finally replaced sometime in March 2018. The DM also stated there had been a lot of dietary staff turn-over. In an interview on 6/15/18 at 12:00 PM, the Administrator stated all grievances should be	F 585	related to the June 2018 dietary grievance related to cold food temperatures. The plate warmer was repaired and will continue to be used to maintain food temperatures for delivery. The Dietary Manager has also revised the meal delivery schedule to further aid in the timeliness and coordination of warm meals. The resident council verbalized satisfaction with the plan and no further reports of cold food have been made. On 7/2/18, the Director of Nursing spoke with Resident #2 daughter who verbalized satisfaction with resolution of stated grievance. A written copy was mailed to residents' daughter, logged on the Grievance Log and original completed Concern form maintained by the Grievance Coordinator per guidelines. 2.) On 7/6/18, the Administrator updated the grievance log from June 2018 forward and will continue to address, record and maintain a copy of all grievances per guidelines. On 7/6/18, the Business Office Manager completed an audit of grievances from 6/15/18 forward to ensure timely resolution, recording and delivery of written response. Any identified discrepancies were corrected as appropriate. 3.) On 7/3/18, the Quality Assurance Consultant provided education to department managers on the process of addressing and recording resident grievances. On 7/3/18, the Administrator provided additional education to facility staff on receiving resident grievances, completion of the Concern form and	

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F 585	Continued From page 13 addressed when voiced. She further stated it was her expectation that there be written follow up to the person voicing the concern. 2. Resident #2 was admitted to the facility on 7/16/08 with multiple diagnoses including cerebrovascular accident (CVA). The annual Minimum Data Set (MDS) assessment dated 3/16/18 indicated that Resident #2's cognition was intact. On 6/14/18 at 9:40 AM, Resident #2 was interviewed. She alleged that Nursing Assistant (NA) #5 had wiped her bottom too hard when providing incontinent care. Resident #2 also stated that NA #5 was ignoring her call light. On 6/14/18 at 2:50 PM, NA #5 was interviewed. She stated that Resident #2 had accused her for not providing care and for being rough to her during incontinent care. NA #5 stated that the DON was aware of the accusation. On 6/14/18 at 3:45 PM, a family member of Resident #2 was interviewed. The family member stated that she had filed grievances to the Director of Nursing (DON) regarding NA #5 being rough to Resident #2 during care and staff members ignoring the call lights. The family member stated that these grievances had been discussed with the DON months ago and she never heard from her of any action taken or any resolution to her concerns. Review of the grievance log for the last 6 months, there were no grievances written or recorded for Resident #2.	F 585	prompt delivery to the Grievance Coordinator. Newly hired department managers will be educated upon hire, and prior to starting work. All facility staff are responsible for receiving resident grievances, completing Concern forms and promptly delivering to the Grievance Coordinator. Upon receipt, the Grievance Coordinator will then be responsible for logging on the Grievance Log and assigning the concern to the appropriate department head for timely investigation and resolution. The resolution will then be recorded with written resolution provided to the concerned resident of facility member. The original completed grievance will be maintained by the Grievance Council for a minimum of three years per regulations. 4.) The Business Office Manager will complete audits of resident grievances for appropriate follow up and record keeping. Audits to be completed at a frequency of weekly for 4 weeks, then monthly for 2 months. The QAPI committee will meet at a minimum of monthly to review the results of the audit findings, evaluate the effectiveness of the monitoring and make changes to the plan as appropriate to ensure the continued resolution of resident grievances. 5.) The Administrator is responsible for the implementation and execution of this plan. 6.) Completion Date: 7/09/18	

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F 585	Continued From page 14 On 6/15/18 at 9:05 AM, the Director of Nursing (DON) was interviewed. The DON stated that the daughter of Resident #2 had filed grievances regarding NA #5 and call lights not being answered. The DON stated that she thought she had written a grievance form but obviously not. She also verified that she had not provided the resident or the family member with a written grievance summary.	F 585		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to provide showers as scheduled for activities of daily living (ADLs) a dependent resident. This was for 1 (Resident #8) of 2 residents reviewed for ADLs. The findings included: Resident #8 was admitted 01/11/17 with Chronic Obstructive Pulmonary Disease (COPD). Resident #8's quarterly Minimum Data Set dated 5/15/18 indicated moderate cognitive impairment with no behaviors. She was coded for total assistance with bathing and for hospice services. In an observation on 6/14/18 at 10:20 AM, Resident #8 was lying in bed. She appeared disheveled. There was no evidence of poor hygiene or odors. She was unable to confirm if she received a shower yet.	F 677	F667- ADL care provided for dependent residents 1.) It is the practice of this facility to provide ADL care and provide shower for dependent residents requiring staff assistance per residents' plan of care. On 7/3/18, the Interdisciplinary Team (IDT) held a Quality Assurance Performance Improvement (QAPI) meeting to discuss the findings of the deficiencies and conduct a root cause analysis for plan of correction. The IDT members present included the Administrator, DON, Dietary Manager, Activities Director, Social Worker, Quality Assurance Consultant, MDS, Therapy Manager, Maintenance Director, Housekeeping Manager and Registered Dietitian. It was determined that the facility did not maintain a process for reviewing	7/9/18

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F 677	Continued From page 15 Review of the shower schedule indicated Resident #9 was to receive showers every Monday and Thursday on first shift. Review of the daily ADL record for Resident #8 indicated she received no showers from 6/01/18 through 6/15/18. There was no care plan for refusal of her activities of daily living. In an interview on 6/15/18 at 9:40 AM, Nursing Assistant (NA) # 3 stated she did not always complete showers due to staffing or getting busy caring for another resident. In an interview on 6/15/18 at 10:00 AM, NA #2 stated she did not always complete her shower assignment. She stated she felt it was due to short staffing or Resident #8 refused her shower. NA #2 stated when she missed completing her showers, she reported it to the charge nurse or Assistant Director of Nursing (ADON) and tried to complete the shower the next day. Review of the daily staffing hours from 6/1/18 through 6/15/18 indicated adequate staffing for facility census. In an interview on 6/15/18 at 11:28 AM, the ADON stated the hospice aide visited Resident #8 twice weekly but the hospice aide only completed a bed bath and washed her hair twice weekly. He stated he was unaware that Resident #8 was not receiving her showers and scheduled. The ADON stated there was no issues with facility staffing and it was expectation that Resident #8 receive her showers as scheduled. He further stated it was his expectation that if an aide was unable to complete her/his assignment, it should be	F 677	the completion of resident showers as scheduled. Resident #8 will continue to receive staff assistance with showers as scheduled and per the residents' plan of care and Kardex. 2.) On date 7/4-7/5/2018 the MDS coordinator completed an audit of dependent residents to validate bathing preferences and update ADL care plan, Kardex and Shower Schedule accordingly. The audit identified Residents' ADL care plan, Kardex and Shower Schedule was updated accordingly as identified. 3.) On 7/09/18, the Director of Nursing completed inservicing to nursing staff on the process for ensuring dependent residents receive showers as scheduled and per residents ADL plan of care. All PRN nursing staff will receive education prior to working their next scheduled shift. The admitting licensed nurse will be responsible for assessing the residents' bathing preferences and initiating the residents' ADL plan of care, Kardex and Shower Schedule accordingly. The nurse aide will complete resident showers per Kardex and shower schedule, complete a Skin Sheet and document in Point of Care (POC). If a shower is not completed or refused, the licensed nurse will be notified. Upon notification, the licensed nurse will make another attempt to have shower completed and will report noncompliance or other related concerns to physician for continued refusals and	

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F 677	Continued From page 16 reported to the charge nurse or the ADON. In an interview on 6/15/18 at 12:00 PM, the Director of Nursing (DON) stated she was not aware that Resident #8 was not receiving her scheduled showers and it was her expectation that Resident #8 receive her showers as scheduled.	F 677	follow his/her recommendations as indicated. Skin Sheets will be reviewed by the nurse supervisor prior to the end of each shift for compliance and placed in the 24 hour report book for additional review in the daily clinical meeting. 4.) The DON or Nurse Supervisor will complete audits of 5 dependent residents to ensure completion of showers per ADL plan of care. Audits will be completed at a frequency of twice weekly for 4 weeks then, weekly for 8 weeks. The QAPI committee will meet at a minimum of monthly to review the results of the audit findings, evaluate the effectiveness of the monitoring and make changes to the plan as appropriate to ensure dependent residents receive showers per plan of care. 5.) Shower sheets will be reviewed during morning clinical meeting and matched to the shower list. Residents identified as not receiving their scheduled shower and did not refuse, will be given their shower immediately. 6.) The Administrator is responsible for the implementation and execution of this plan. 7.) Completion Date: 7/09/18	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		7/12/18

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F 684	Continued From page 17 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 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 staff and resident interviews and record review, the facility failed to provide treatments as ordered for 1 (Resident #1) of 2 residents reviewed for well-being. The findings included: Resident #1 was admitted 12/9/16 with cumulative diagnoses of Lymphedema, Diabetes, Peripheral Arterial Disease and amputation of his bilateral legs above the knee. Review of a grievance on behalf of Resident #1 dated 3/5/18 read he reported the dressing to his right thigh and not been changed in several days. The form was completed by Nurse #2. The dressing to his right thigh was observed by the Director of Nursing (DON) present. The right thigh dressing was dated 3/1/18. The resolution read the nurse who provided Resident #1's treatments to his right thigh from 3/1/18 through 3/4/18 was educated on completed treatments as ordered. Review of Resident #1's March 2018 treatment order to his right thigh read as follows: Clean open area on right thing with house wound cleanser, pat dry, apply Silver Sulfadiazine	F 684	F684- Quality of Care 1.) It is the practice of this facility to provide skin treatments as ordered to ensure residents' highest well-being and quality of care. On 7/3/18, the Interdisciplinary Team (IDT) held a Quality Assurance Performance Improvement (QAPI) meeting to discuss the findings of the deficiencies and conduct a root cause analysis for plan of correction. The IDT members present included the Administrator, DON, Dietary Manager, Activities Director, Social Worker, Quality Assurance Consultant, MDS, Therapy Manager, Maintenance Director, Housekeeping Manager and Registered Dietitian. It was determined that the facility did complete routine visual observations of residents' dressing to validate date changed per frequency ordered. Resident #1 no longer resides at the facility. 2.) On date 7/5/2018, the DON completed an audit of residents with skin treatment orders by visually observing dates on dressings to match frequency ordered. No further discrepancies were identified.	

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F 684	Continued From page 18 (ointment sued to treat skin infections) every day until healed. The date of this original order was 1/26/18. Review of Resident #1's March 2018 Treatment Administration Record (TAR) indicated the same nurse initials for 3/2/18, 3/3/18 and 3/4/18 indicating the treatments were completed to his right thigh. Review of an Employee Warning Notice dated 3/30/18 read the nurse assigned to complete Resident #1's treatments on 3/2/18, 3/3/18 and 3/4/18 was counseled to carry out job responsibilities without error. He was instructed to administer treatment according to the nursing practice guidelines. The assigned nurses written response to the warning notices read as follows: "Will make sure to follow all instructions from the point forward." The warning notice was signed by the assigned nurse and the DON dated 3/30/18. Attached to the warning notice was a copy of the March TAR for Resident #1 with his initials indicating completion of the treatment to his left thigh was completed 3/2/18, 3/3/18 and 3/4/18. Review of Resident #1's quarterly Minimum Data Set dated 5/21/18 indicated he was cognitively intact, exhibited no behaviors and required extensive assistance with most of his activities of daily living. Review of Resident #1's May 2018 treatment order to his right thigh read as follows: Clean right medial upper leg with normal saline, pat dry,	F 684	3.) On 7/03/18, the Director of Nursing (DON) provided initiated reeducation to licensed nurses on completing and documenting skin care treatments as ordered. All licensed nurses will be educated prior to their next scheduled shift. The licensed nurse is responsible for completing resident skin treatments as ordered by the physician. Dressings shall be dated/initialed by the licensed nurses and then documented on the Treatment Administration Record (TAR). The Unit Manager will conduct random observations of resident dressings against ordered frequency to monitor compliance and to ensure resident quality of care. The DON will also monitor compliance during weekly skin QA meetings. 4.) The DON or Nurse Supervisor will complete audits of 5 random residents with skin treatment orders for compliance. Audits to be completed at a frequency of twice weekly for 4 weeks, then weekly for 8 weeks. The QAPI committee will meet at a minimum of monthly to review the results of the audit findings, evaluate the effectiveness of the monitoring and make changes to the plan as appropriate to ensure the continued compliance with dressing changes per physicians orders to maintain residents quality of care 5.) The Administrator is responsible for the implementation and execution of this plan.	

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F 684	Continued From page 19 apply medi-honey (medical grade honey used to treat wounds) gel to the wound bed, cover with Adaptec (non-stick dressing), 4X4 gauze, then ABD (abnormal pad use to cover a large wound or wound with excessive drainage) pad and secure with tape. Ace wrap to right upper thigh daily and as needed. The date of this new order was 5/22/18. Resident #1's latest revised care plan dated 6/8/18 indicated he had skin alterations and treatment were to be done as ordered. In an interview on 6/14/18 at 2:14 PM, Nurse #2 confirmed she completed the grievance form for Resident #1 dated 3/5/18. She also confirmed the previous DON was present when the dressing was assessed to determine when it was last changed. She stated she could not recall the date on the dressing but it had not been changed in a "couple of days". In an interview on 6/15/18 at 8:40 AM, Resident #1 stated a few months ago, he was not dressing the dressing to his right thigh changed every day. He stated the nurse assigned 3/2/18, 3/3/18 and 3/4/18 stated the physician did not order the dressing to his right thigh to be changed every day. Resident #1 stated he was not aware of any changes in the frequency of the treatments to his right thigh by the physician at the wound clinic. He did state he thought they were using honey of his wound now but it was changed every day and has been since he said something about it not being done.	F 684	6.) Completion Date: 7/09/18	

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F 684	Continued From page 20 In an interview on 6/15/18 at 9:30 AM, the Administrator stated the assigned nurse was out of the country and not expected to return until 6/18/18. She stated it was her expectation that Resident #1's treatment be done daily as ordered. In an interview on 6/15/18 at 12:00 PM, the DON stated the previous DON was involved in the incident with Resident #1 not receiving his treatment for a few days in March. She stated it was her expectation that Resident #1 receive his treatments daily and as ordered.	F 684		
F 732 SS=E	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows:	F 732		7/12/18

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 21 (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed for accurately post the nursing hours for 15 of 15 days reviewed for accuracy. The findings included: Review of the posted nursing hours from June 1, 2018 through June 15, 2018 did not include the daily actual nursing hours worked or daily facility census. In an interview on 6/15/18 at 11:20 AM, the Staff Coordinator stated she started her position two months ago and was never instructed to include the daily actual nursing hours worked or the daily facility census on the posting form. In an interview on 6/15/18 at 12:00 PM, the Administrator stated the nursing hour posting for the public should include the actual daily nursing hours worked along with the daily facility census. She stated it was her expectation the nursing hours posting be accurate and complete.	F 732	F732- Posted Nurse Staffing Information 1.) It is the practice of this facility to accurately post required nurse staffing information. On 7/3/18, the Interdisciplinary Team (IDT) held a Quality Assurance Performance Improvement (QAPI) meeting to discuss the findings of the deficiencies and conduct a root cause analysis for plan of correction. The IDT members present included the Administrator, DON, Dietary Manager, Activities Director, Social Worker, Quality Assurance Consultant, MDS, Therapy Manager, Maintenance Director, Housekeeping Manager and Registered Dietitian. It was determined that the facility did not maintain a process for accurately recording actual nursing hours and census information and retaining records for at least 18 months per guidelines.	

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	345177	A. BUILDING _____ B. WING _____	C 06/15/2018

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F 732	Continued From page 22	F 732	On date 7/6/2018, the facility scheduler reviewed payroll records and census data for 6/15/18 forward and completed an accurate nurse staffing form to maintain for record keeping requirements. 2.) The facility will continue to ensure the accurate posting and record keeping of nurse staffing information per guidelines. 3.) By 7/09/18, the Administrator and Director of Nursing provided education to the scheduler, department heads (as manager on duty) and to nurse supervisors on the process for accurately posting and maintaining nurse staffing hours. All department heads will be educated prior to working their next scheduled shift. The scheduler will be responsible for posting daily nurse staffing information and maintaining records in an organized filing system. Information will include census and scheduled or proposed nursing hours by shift. The nurse supervisor will be responsible for posting the actual hours worked for his/her shift. The manager on duty will be responsible for monitoring the daily compliance and accuracy of the posting. The daily Nursing Staffing sheet will be located in the facility lobby and then maintained by the scheduler for a minimum of 18 months. 4.) The Business office Manager will complete audits to ensure the accurate posting and record keeping of nurse staffing hours. Audits to be completed at a frequency of twice weekly for 4 weeks,	

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F 732	Continued From page 23	F 732	then weekly for 8 weeks. The QAPI committee will meet at a minimum of monthly to review the results of the audit findings, evaluate the effectiveness of the monitoring and make changes to the plan as appropriate to ensure the continued posting and maintenance of accurate nurse staffing hours. 5.) The Administrator is responsible for the implementation and execution of this plan. 6.) Completion Date: 7/09/18	
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on records review, observation and staff and resident interview, the facility failed to serve food at an acceptable temperature for 2 (breakfast and lunch) of 2 meal observations. Findings included: 1. The resident council minutes were reviewed. The minutes dated 1/24/18 indicated "breakfast always cold", 4/25/18 "food too cold", 4/30/18 "breakfast was cold", 5/9/18 "food temperature"	F 804	F804- Nutritive Value/Appearance, Palatable/Preferred Temperature. 1.) It is the practice of this facility to provide palatable food at an acceptable temperature to the resident. On 7/3/18, the Interdisciplinary Team (IDT) held a Quality Assurance Performance Improvement (QAPI) meeting to discuss the findings of the deficiencies and conduct a root cause	7/12/18

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F 804	Continued From page 24 and 5/29/18 "food cold". On 6/15/18 at 7:37 AM, Resident #4, the President of the resident council was interviewed. She stated that the food continued to be served cold in her room and in the dining room. She stated the Resident Council had discussed the cold food but there had been no follow up with the group. 2. Resident # 10 was admitted to the facility on 5/31/18 with multiple diagnoses including Chronic Obstructive Pulmonary Disease (COPD). The admission Minimum Data Set (MDS) assessment dated 6/6/18 indicated that Resident #10's cognition was intact. On 6/14/18, a lunch meal observation was conducted. At 11:50 AM, the cart arrived on the hall. There was no staff member observed at the cart until 12:00 PM. Prior to serving the trays, the two Nursing Assistants (NAs) had to fill all cups with ice and tea. At 12:20 PM, the two NAs started to pass the trays to residents who were able to feed themselves. Resident #10 received his lunch tray at 12:25 PM. His tray contained a bowl of vegetable soup. The soup was cold to touch. He stated that he had been complaining about cold food but nothing had been done about it. On 6/14/18 at 4:30 PM, the Dietary Manager (DM) was interviewed. She stated that she started working at the facility as DM in January 2018. She was made aware of resident's concerns with cold food. The plate warmer and the base warmer were broken and were not replaced sooner as expected and that contributed to the problem with cold food. The DM also	F 804	analysis for plan of correction. The IDT members present included the Administrator, DON, Dietary Manager, Activities Director, Social Worker, Quality Assurance Consultant, MDS, Therapy Manager, Maintenance Director, Housekeeping Manager and Registered Dietitian. It was determined that the facility did not have a meal service system that ensured residents were being served meals at the same time. On 7/3/18, the Quality Assurance nurse completed an audit for Resident #4 and #10 by visually observing lunch service and resident questionnaire. Both residents were observed eating a palatable meal and no concerns regarding food temperatures were reported or noted. 2.) On date 7/6/2018 the Administrator completed an audit of alert and oriented residents by questionnaire to ensure residents receive meals at an acceptable temperature. Any concerns were addressed per the company grievance guideline. The plate warmer was repaired and will continue to be used to maintain food temperatures for delivery. The Dietary Manager has also revised the meal delivery schedule to further aid in the timeliness and coordination of warm meals. 3.) By 7/03/18, DON reeducated the staff on providing resident meals at an acceptable temperature. All staff will be educated prior to working their next scheduled shift.	

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F 804	Continued From page 25 indicated that she had a lot of dietary staff turnover. On 6/15/18, a breakfast meal observation was again conducted. At 9:15 AM, Resident #10's breakfast tray was observed. He had a bowl of grits in his tray and was not touched. When asked, he stated that the grits was cold and was hard. When touch, the grits was cold.	F 804	The dietary staff will ensure meals are covered and delivered timely on a plate warmer. All staff will be responsible for addressing resident concerns of food temperatures and offering to promptly warm food if needed or requested by the resident and then complete Concern form for follow up by the Grievance Coordinator. 4.) The Activities Director/Medical Records will complete audits of 5 random residents to ensure acceptable food temperatures. Audits to be completed at a frequency of twice weekly for 4 weeks, then weekly for 8 weeks. The QAPI committee will meet at a minimum of monthly to review the results of the audit findings, evaluate the effectiveness of the monitoring and make changes to the plan as appropriate to ensure the continued service of resident meals at acceptable temperatures and palatability. 5.) The Administrator is responsible for the implementation and execution of this plan. 6.) Completion Date: 7/09/18	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		7/12/18

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F 880	Continued From page 26 diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility	F 880		

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F 880	Continued From page 27 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews and record review, the facility failed to visibly post Contact Precautions with instructions for 2 (Resident #6 and Resident #9) of 2 residents diagnosed with Clostridium difficile (C-diff: bacterial infection of the large intestines easily spreads through direct contact). The findings include: 1. Resident #6 was newly diagnosed with C-diff on 6/12/18 with orders to place on Contact Precautions. Observation on 6/14/18 at 9:47 AM revealed an isolation cart outside Resident #6's door in the hall. Inside the cart was gloves, isolation gowns and mask. Observed on the door frame of Resident #6's door was a magnetic sign that	F 880	F880- Infection Prevention & Control 1.) It is the practice of this facility to visibly post Contact Precautions with instructions for residents with C. Diff. On 7/3/18, the Interdisciplinary Team (IDT) held a Quality Assurance Performance Improvement (QAPI) meeting to discuss the findings of the deficiencies and conduct a root cause analysis for plan of correction. It was determined that the facility did not have appropriate signage available for posting. On 6/15/18, the DON posted Contact Isolation signage with instructions for Resident #6 and #9. On 7/3/18, the Quality Assurance nurse completed an audit for Resident #6 and #9. Resident #6 is no longer on Contact	

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F 880	Continued From page 28 read: "Stop-see nurse for instruction." In an interview on 6/14/18 at 9:47 AM, Nurse #1 stated she was unsure why Resident #6 was on Contact Precaution. She stated she used the personal protective equipment (PPE-gloves, gown and mask) to be safe. In an interview on 6/14/18 at 3:25 PM, Nursing Assistant (NA) #1 stated he was aware that Resident #6 had an infection but unsure as to where. NA #1 stated she wore gloves when assisting Resident #6 and a gown if she "felt uncomfortable" caring for him due to the infection. In an interview on 6/14/18 at 3:40 PM, Resident #6 stated he was receiving antibiotics for C-diff. He stated the staff were inconsistent with what PPE they wore while in his room. He verified he was continent of bowel and self-toileted. Resident #6 stated the loose stools had subsided. In an interview on 6/14/18 at 4:15 PM, the Assistant Director of Nursing (ADON) stated he was the facility Infection Control Preventionist (ICP). He stated he was aware the incorrect signage was posted but his corporate supervisors stated Centers of Disease Control (CDC) signage was a confidentiality issue and directed him to use the "Stop-see nurse for instruction" signage. In an interview on 6/15/18 at 12:00 PM, the Director of Nursing (DON) stated it was her expectation that the CDC Contact Precaution signage be posted to inform staff and visitors of precautions required. 2. Resident #9 was readmitted on 6/8/18 with C-diff.	F 880	Precautions and Resident #9 continues to have appropriate Contact Isolation signage with instructions posted as ordered. 2.) On 7/3/18, the Quality Assurance Consultant completed an audit of residents with transmission-based precaution orders to ensure appropriate postings with instructions. No other residents were identified. 3.) On 6/15/18, the Director of Nursing reeducated staff on the process for ensuring appropriate transmission-based precaution signage (Contact, Airborne, Droplet) with instructions to aid in the prevention of the transmission of infections among residents. All staff will receive education prior to working their next scheduled shift. The licensed nurse receiving the physician order for transmission-based precautions will be responsible for posting the appropriate signage on the residents' door to properly alert others. Facility staff are responsible for following the instructions on the transmission-based precaution signage before providing care to the resident to prevent the transmission of infections to others. 4.) The DON or Nurse Supervisor will complete audits of residents with transmission-based precaution orders to ensure appropriate postings to prevention the spread of infections. Audits to be completed at a frequency of twice weekly	

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F 880	Continued From page 29 Observation on 6/14/18 at 2:25 PM revealed an isolation cart outside Resident #9's door in the hall. Inside the cart was gloves, isolation gowns and mask. Observed on the door frame of Resident #9's door was a magnetic sign that read: "Stop-see nurse for instruction". In an interview on 6/14/18 at 2:25 PM, NA #2 stated she was unsure why Resident #9 was on Contact Precautions. In an interview on 6/14/18 at 2:40 PM, Resident #9 stated she was first diagnosed with C-diff in May 2018. She stated the staff were inconsistent with the PPE used when caring for her. In an interview on 6/14/18 at 4:15 PM, the ADON stated he was the facility ICP. He stated he was aware the incorrect signage was posted but his corporate supervisors stated Centers of Disease Control (CDC) signage was a confidentiality issue and directed him to use the "Stop-see nurse for instruction" signage. In an interview on 6/15/18 at 12:00 PM, the DON stated it was her expectation that the CDC Contact Precaution signage be posted to inform staff and visitors of precautions required.	F 880	for 4 weeks, then weekly for 8 weeks. The QAPI committee will meet at a minimum of monthly to review the results of the audit findings, evaluate the effectiveness of the monitoring and make changes to the plan as appropriate to ensure the accurate posting for residents on transmission-based precautions and to prevent the spread of infection. 5.) The Administrator is responsible for the implementation and execution of this plan. 6.) Completion Date: 7/09/18	