STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345496	A. BUILDING _____ B. WING _____	C 09/12/2018

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LIBERTY COMMONS N&R ALAMANCE	791 BOONE STATION DRIVE BURLINGTON, NC 27215

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F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on record review and resident, responsible party and staff interviews, the facility failed to invite the resident or resident responsible	F 553	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the	10/8/18

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

Electronically Signed | 09/28/2018

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F 553	Continued From page 1 party to participate in the development of care plans for 2 of 18 residents whose care plans were reviewed (Residents #61 and #35). Findings included: 1. Resident #61 was admitted to the facility on 1/26/18 with the current diagnoses of Epilepsy, Thrombocytopenia, Major Depressive Disorder (single episode) and Hypertension. Resident #61 Minimum Data Set (MDS) dated 8/17/18 coded as quarterly assessment revealed Resident # 61 to be cognitively intact with no behavior or sign or symptoms of psychosis. Resident was assessed as having clear speech and adequate hearing. The resident's care plans were last updated on 8/11/18. There was no progress note or documentation to indicate Resident # 61 or the responsible party participated in the development of the resident's care plan during the period of 1/26/18 through 8/23/18. During an interview on 9/11/18 at 4:56 PM, Resident # 61 stated she does not recall staff discussing her plan of care. Resident# 61 also stated she was not invited to her care plan meeting. During an interview on 9/12/18 at 12:27 PM, the MDS nurse stated the care plan meetings were set up by the social worker and the resident and resident representative were invited. Nurse further stated the social worker no longer worked in the facility.	F 553	alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 553 Plan for correcting the specific deficiency and including what processes that lead to deficiency cited. The facility failed to invite the resident or resident responsible party to participate in the development of care plans for 2 of 18 residents whose care plans were reviewed. *Resident #61 received verbal invitation from the Social Services Director on 9/28/18 to attend her upcoming care planning conference scheduled for 10/4/18. Resident representative for resident #61was also invited to attend a care planning conference by letter which was mailed via certified mail on 9/28/18. *Resident #35 received verbal invitation from the Social Services Director on 9/28/18 to attend her upcoming care planning conference	

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F 553	Continued From page 2 Facility was not able to produce any documents that indicate the resident or resident representative were invited and had attended the resident's care plan meetings. 2. Resident # 35 was admitted to the facility on 2/26/18 with the current diagnoses of Chronic Kidney Disease (Stage 5), Cirrhosis of Liver, Chronic Obstructive Pulmonary Disease, Disorder of Urea Cycle Metabolism and Dependence of Supplemental Oxygen Resident #35 Minimum Data Set (MDS) dated 7/23/18 coded as quarterly assessment revealed Resident # 35 was readmitted to the facility on 3/12/18. The resident was assessed to be cognitively intact with no behavior or sign or symptoms of psychosis. Resident was on hospice care. The resident's care plans were last updated on 7/23/18. There was no progress note, or documentation to indicate Resident # 35 or the responsible party participated in the development of the resident's care plan during the period of 1/26/18 through 8/23/18. During an interview on 9/10/18 at 3:19 PM, Resident # 35's representative stated the resident or resident representative were not invited to her care plan meeting. During an interview on 9/12/18 at 12:27 PM, the MDS nurse stated the care plan meetings were set up by the social worker and the resident and resident representative were invited. Nurse	F 553	scheduled for 10/4/18. Resident representative for resident #35 was also invited to attend a care planning conference by letter which was mailed via certified mail on 9/28/18. The process identified that lead to this area of concern is that after the previous Social Services Director resigned from the facility, no one assumed the responsibility of ensuring that all residents and their representatives were invited to attend and to be included in their care planning conferences. The facility process is that the MDS nurse provide the Social Services Director with a list of all residents who are scheduled to have an MDS assessment within the upcoming month. Based upon this list, the Social Services Director will extend verbal invitations to residents, as well as mail invitations to their resident representatives inviting them to attend/participate in upcoming care planning conferences. A copy of letters mailed will be maintained by the Social Service Director. Social Service Director will document verbal invitations extended to residents in his/her progress notes along with resident□s response. In the absence of the Social Services Director, the MDS Nurse will ensure that the above-mentioned care plan conference invitation process is followed. Procedure for implementing the acceptable plan of correction for specific deficiency. The MDS Consultant provided education	

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F 553	Continued From page 3 further stated the social worker no longer worked in the facility. Facility was not able to produce any documents that indicate the resident or resident representative were invited and had attended the meeting. During an interview on 9/12/18 at 5:30 PM. The facility corporative consultant stated the previous social worker was no longer working for the facility and the new social worker had joined the facility a week ago. She also stated the facility was unable to provide any other information on care plan meeting for this resident. She indicated the resident and resident representatives should be included in the care plan meeting. She further indicated she would expect for the resident and resident representatives to be offered to attend the care plan meeting.	F 553	to the MDS Nurse Social Services Director on 9/28/18. Information Provided on Education included: *It is every resident□s and his/her representative□s right to be involved in his/her care planning process, which includes being invited to attend care planning conferences. Care planning conferences should be held for each resident on a quarterly basis at minimum. *Having the resident□s voice heard in the assessment and care planning process is very important in formulating the most accurate and individualized care plan. Having representative/family input can also provide valuable insight to resident□s preferences, strengths, customary routines, etc. which are very important aspects of an individualized care plan. *Social Services Director is responsible for extending verbal invitations to residents to attend upcoming care planning conferences. He/she must document that the verbal invitation was extended in the progress notes for resident. This documentation should also include the resident□s acceptance or declination of invitation. *Social Services Director is also responsible for mailing invitations to upcoming care planning conferences to the resident representative. A copy of the mailed invitation must be maintained by the Social Services Director. *In the absence of the Social Services Director, the MDS Nurse will ensure that the invitation process is carried out.	

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F 553	Continued From page 4	F 553	This information has been integrated into the standard orientation training for MDS Nurses and Social Services Directors. Monitoring procedure to ensure the plan of correction is effective and specific deficiency remains corrected and/or in compliance with the regulatory requirements. The Director of Nursing or designee will perform Quality Assurance Audits by using the tool entitled Care Plan Conference Invitation Audit Tool. This audit will be completed weekly for 4 weeks and then monthly for 2 months. This quality assurance audit will start on 10/1/18. The Administrator will monitor completion of these Quality Assurance audits to ensure regulatory compliance. Any negative findings will immediately be addressed. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, Activity Director, Admissions Coordinator and the Dietary Manager. Title of person responsible for implementing the acceptable plan of correction.	

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F 553	Continued From page 5	F 553	The Administrator is responsible for implementation and completion of the acceptable plan of correction.	
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary	F 655		10/8/18

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F 655	Continued From page 6 of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a baseline care plan with clinical information to provide effective person-centered care for four of six residents reviewed for baseline care plans (Residents #71, #72, #271 and #272). Findings included: 1. Resident #71 was admitted to the facility on 06/21/18. Diagnoses included, in part, joint replacement, diabetes mellitus (DM), depression, asthma, anxiety, chronic pain, and gastrointestinal reflux disease (GERD). The Minimum Data Set (MDS) five-day assessment dated 6/26/18 revealed Resident #71 was cognitively intact and required extensive assistance with bed mobility, transfer, walking, locomotion, dressing and bathing. She was unsteady during transfers and had lower extremity impairment on one side. A review of the care plan dated 06/22/18 revealed that there were no care plan interventions regarding the joint replacement, DM, depression, anxiety, chronic pain or GERD.	F 655	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 655 Plan for correcting the specific deficiency and including what processes that lead to deficiency cited All residents who have been admitted within the past 21 days from 9/7/18 – 9/28/18 will be reviewed to validate whether the Baseline Care Plan requirements have been met. Any resident reviewed who does not yet have	

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F 655	Continued From page 7 An interview was conducted with the MDS Nurse #4 on 09/12/18 at 3:45 p.m. who indicated there were not any baseline care plans for the residents. The admitting nurses were responsible for implementing the baseline care plan. An interview on 9/12/18 at 5:30 p.m., the corporate consultant stated all residents should have a baseline care plan within 48 hours of admission. She confirmed staff did not develop a baseline care plan for Resident #71. An interview was conducted with Nurse #1 on 09/12/18 at 6:25 p.m. who indicated that when she admitted a new resident to the facility she did the falls risk assessment and the nursing admission note. She specified that she was not able to get into the electric health record system to do care plans. The care plans were done by someone else; she didn ' t know who. She had not created any care plans or care plan changes. She stated, "I haven ' t been taught." 2. Resident #72 was admitted to the facility on 05/31/18 with diagnoses that included congestive heart failure, vascular dementia, cerebral infraction and dependence on supplemental oxygen. Record review of the Discharge MDS assessment dated 06/17/18 revealed that Resident #72 had a planned discharged. Resident was assessed as cognitively intact and required extensive assistance to total dependence for all activities of daily living (ADLs). A record review revealed no baseline care plan for the resident.	F 655	a comprehensive care plan will have a Baseline Care Plan completed to include: resident's initial goals, medication and dietary orders, Clinical instructions/orders on how to provide safe/effective care for resident such as: surgical aftercare, joint replacement aftercare, application of ordered slings or braces, maintaining contact precautions, etc., ordered therapy and/or social services and PASAR update referrals if applicable. This summary will be printed and reviewed with the resident and/or representative. The resident and/or representative will be provided with a copy that has been signed by them as well as the MDS Nurse. A copy will also be uploaded into resident's electronic health record in Point Click Care. Any resident reviewed who does have a comprehensive care plan will have their care plan reviewed with them and/or their representative by the MDS Nurse. They will also be provided a signed copy of this care plan. This will be completed by the MDS Nurse no later than 10/3/18. The process identified that lead to this area of concern is that the MDS Nurse failed to initiate and complete the Baseline Care Plan for residents within 48 hours of admission. This was caused by a knowledge deficit, as the MDS Nurse had a misunderstanding that staff nurses were completing the requirements for Baseline Care Plans. Procedure for implementing the acceptable plan of correction for specific deficiency	

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F 655	Continued From page 8 During an interview on 09/12/18 at 12:22 p.m., MDS Nurse stated she was not responsible for the baseline care plan. She further stated that the admission nurse was responsible for developing a baseline care plan. She also indicated she developed the comprehensive care plan based on hospital and admission records. During an interview on 09/12/18 at 1:14 p.m., Nurse #1 stated that an admission/readmission assessment and a risk assessment were completed when any resident was admitted to the unit. Nurse #1 also stated the baseline care plan was completed by the Director of Nursing (DON) or the MDS Nurse. She further stated that nursing staff did not have access to create or change care plans. During an interview on 09/12/18 at 1:49 p.m., Nurse #3 stated she did not create or generate a baseline care plan. Nurse #3 further stated that during admission or reentry a resident ' s assessment and risk assessment were completed by the admission nurse. She was unsure who did the care plan and how there were updated. Nurse #3 also stated that any changes needed for the care plan were usually reported to the unit manager or DON. During an interview on 09/12/18 at 5:30 p.m., the facility corporate consultant confirmed that staff did not develop a base line care plan for Resident #72. She stated that all residents should have a baseline care plan within 48 hours upon admission. 3. Resident #271 was admitted 09/06/18 with diagnoses that included right-sided hemiplegia and hemiparesis following a cerebrovascular	F 655	The MDS Consultant provided education related to Baseline Care Plan requirements and the facility procedure to ensure that the requirement is met going forward. This education was provided to the MDS Nurse, Social Services Director on 9/28/18. Education will be provided to the Director of Nursing and Assistant Director of Nursing on 10/3/18. Information Provided on Education included: The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must: •Be developed within 48 hours of a resident's admission. •Include the minimum healthcare information necessary to properly care for a resident including, but not limited to: •Clinical instructions/orders on how to provide safe/effective care for resident such as: surgical aftercare, joint replacement aftercare, application of ordered slings or braces, maintaining contact precautions, etc. •Initial goals based on admission orders. •Physician orders. •Dietary orders. •Therapy services. •Social services.	

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F 655	Continued From page 9 accident (CVA), frontal lobe and executive function deficit following a CVA and enterocolitis due to Clostridium difficile (C. diff). The admission MDS was not yet completed at the time of the survey. A physician order was documented 09/06/18 to "admit to skilled level of care for CVA, C. diff." Fidaxomicin (an antibiotic) was started 09/07/18 for the indication of C. diff. On the Nursing Admission Assessment checklist dated 09/06/18 Resident #271 was checked as having an active case of C. diff that required contact precautions. Nursing progress notes dated 09/09/18 and 09/10/18 noted the continued requirement for isolation and contact precautions for Resident #271 related to infection from C. diff. Resident #271 was observed on contact precautions throughout the survey. A review of the electronic health record for Resident #271 indicated that a care plan was initiated 09/07/18 by the Food Service Director with one entry indicating that the resident was on a therapeutic diet. The necessity of contact precautions for an active case of C. diff was not listed. In an interview on 09/12/18 at 11:12 a.m., the Nurse Manager of the Rehab Unit confirmed that the need for contact precautions was not listed on the baseline care plan for Resident #271. She stated that the baseline care plan should reflect relevant clinical issues in order to provide guidance on care for newly admitted residents. In an interview on 09/12/18 at 12:32 p.m., the	F 655	•PASARR recommendation, if applicable. The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan is developed within 48 hours of the resident's admission. •Meets all the requirements for included content of a baseline care plan. The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: The initial goals of the resident, A summary of the resident's medications and Dietary instructions. •Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. •Any updated information based on the details of the comprehensive care plan, as necessary. ¿ It is the responsibility of the MDS Nurse to ensure that the Baseline Care plan is completed and reviewed with the resident and/or representative. ¿ In the absence of the MDS Nurse, the Social Services Director should ensure that the Baseline Care Plan is completed and reviewed with the resident and/or representative. ¿ In the absence of both the MDS Nurse and Social Services Director, the DON or designee shall ensure that the Baseline Care Plan is completed and reviewed with the resident and/or	

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F 655	Continued From page 10 MDS Coordinator stated that she typically did not review the baseline care plan of newly admitted residents. The nurse who admitted the resident was the one who generally started the care planning process. The MDS Coordinator stated that she added entries to the care plan after completing the admission MDS within seven days of the resident ' s admission. She indicated that that she did attend the weekday stand-up meetings where care issues were discussed. She reviewed admission orders and, if a resident was admitted from another facility, the discharge summary. In an interview on 09/12/18 at 11:12 a.m., the DON acknowledged that the diagnosis of C. diff for Resident #271 documented on admission was an essential consideration of nursing care. She shared her expectation that the need for contact precautions be listed on the baseline care plan. 4. Resident #272 was admitted 09/07/18 with diagnoses that included a displaced comminuted fracture of the humerus of the right arm, unspecified dementia without behavioral disturbance, and an unspecified fall. The admission MDS was not yet completed at the time of the survey. A Nursing Admission Assessment on 09/07/18 noted that Resident #272 had a right upper extremity immobilizer in place on arrival to the facility. Resident #272 was observed throughout the survey with the immobilizing device applied to her right arm. It consisted of a waist band with two attached bands securing both the wrist and the upper arm to prevent movement.	F 655	representative. This information has been integrated into the standard orientation training for MDS Nurses. Monitoring procedure to ensure the plan of correction is effective and specific deficiency remains corrected and/or in compliance with the regulatory requirements. The Director of Nursing or designee will perform Quality Assurance Audits by using the tool entitled “Baseline Care Plan Audit Tool.” This audit will be completed weekly for 4 weeks and then monthly for 2 months. This quality assurance audit will start on 10/1/18. The Administrator will monitor completion of this Quality Assurance audit to ensure regulatory compliance. Any negative findings will immediately be addressed. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, Activity Director, Admissions Coordinator and the Dietary Manager. Title of person responsible for	

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F 655	Continued From page 11 A review of the nursing progress notes since admission revealed that Resident #272 received pain medication daily for arm pain. A nursing progress note dated 09/09/18 documented that the resident ' s pain increased with movement. Nursing notes dated 09/10/18 to 09/12/18 documented that the immobilizing device was applied to the resident ' s right arm. A review of the electronic health record indicated that two entries were present on the baseline care plan for Resident #272 dated 09/10/18: a planned discharge to the community and a Do Not Resuscitate (DNR) order. There was no entry for the use of an immobilizing device for the resident ' s fractured right humerus. In an interview on 09/12/18 at 3:25 p.m., the DON acknowledged that the baseline care plan did not include an entry for the use of the immobilizer for the resident ' s arm and this limited the nurses ' understanding of how the device was to be applied and for how long. She indicated that the MDS Coordinator had overall responsibility for ensuring completeness of the care plans. She shared her expectation that relevant clinical issues be included in the initial care plan to guide the care of newly admitted residents.	F 655	implementing the acceptable plan of correction The Administrator is responsible for implementation and completion of the acceptable plan of correction.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable	F 656		10/8/18

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F 656	Continued From page 12 objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident and staff interviews, the facility failed to implement the care planned interventions for 1 of 18 sampled	F 656	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the	

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F 656	Continued From page 13 residents (Resident's #28) for two people assistance with bed mobility. Findings include: Resident #28 was admitted on 7/10/18. His diagnoses included quadriplegia (paralysis of all four limbs), depression and anxiety. Review of Resident #28's Quarterly Minimum Data Set, dated 7/10/18, revealed his intact cognition. The resident required extensive assistance with activities of daily living, included bed mobility. Review of resident 28 ' s plan of care, dated 7/4/18, revealed that the resident was at risk for falls due to quadriplegia, with the goal to minimize his risk for falls and multiple interventions, including one-person assistance for bed mobility. This plan of care was updated on 8/6/18, after resident ' s actual fall, to have two-nurse aides ' assistance for bed mobility to promote safety. Record review of Resident 28 ' s nurses ' notes, dated 8/5/2018 at 03:07 AM, revealed that the nurse aide provided care and Resident #28 was "too close to the side of the bed". The nurse aide "broke the fall" and "ease the resident to the floor". Record review of Resident 28 ' s incident report, dated 8/5/18, indicated that on 8/5/18 at 2:36 AM, the resident was found on the floor in his room. The IDT (interdisciplinary team) meeting reviewed the incident and updated the plan of care to have two nurse aides to assist with bed mobility. Record review of Resident 28 ' s Point of Care (resident ' s plan of care, accessible for nurse aides) revealed that it was updated for two-nurse	F 656	alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F656 Plan for correcting specific deficiency. The process that led to deficiency cited. The facility failed to implement the care planned intervention for 1 of 8 sampled residents for two people assistance with bed mobility. The nurse managers audited all current residents to establish which residents were receiving two person assistance with bed mobility. This was completed by reviewing the care task and Activity of Daily Living care plans of all current residents. Once it was determined who had an intervention for two person assistance, the care plan team reviewed the list. A master list was then created and posted at each nurses station for CNA□s to review prior to giving patient care. This will be completed by 10/08/2018. Procedure for implementing the acceptable plan of correction. On 10/04/2018, the Nurse Consultant and or Director of Nursing provided an	

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F 656	Continued From page 14 aides ' assistance with bed mobility. Record review of Resident 28 ' s care tracker for August 2018 revealed that the resident received one-person assistance with bed mobility on 8/8/18 one time, on 8/9/18 - twice, on 8/10/18 - one time, on 8/11/18 - twice, on 8/13/18 - one time, on 8/14/18 - three times, on 8/15/18 - twice and on 8/16/18 - one time. On 8/11/18 at 9:10 AM, during the observation/interview, Resident #28 was in bed. He stated that last month, when the nurse aide changed his adult briefs in the morning, he fell from the bed. The nurse aide slowed him down to the floor. The resident confirmed that before and after the incident, most of the time one person assisted him with bed mobility. On 9/12/18 at 12:10 PM, during the telephone interview, Nurse Aide #3 indicated that she daily worked with Resident #28, and could confirm that the resident received one-person assistance for bed mobility. On 9/12/18 at 12:15 PM, during the telephone interview, Nurse Aide #4 indicated that Resident #28 received one-person assistance for bed mobility. On 9/12/18 at 12:15 PM, during an interview, Nurse Aide #5 indicated that he had Resident #28 in his assignment for this shift. The Nurse Aide stated that the resident received one-person assistance for bed mobility. During an interview, Nurse Aide opened the Point of Care on the portable computer. He was able to demonstrate assignment of two people with lift transfer, but could not find two people assignment for bed mobility. The Nurse Aide confirmed that Resident	F 656	in-service education to all full time, part time, and as needed nurses including nurse managers and MDS nurse, CNA□s, and Medication Tech□s. Topics included: *How to access the kardex for assigned residents and view how many care givers are required for two person assistance. *Where the list of two person assist can be located on each unit. *The MDS coordinator will be responsible for updating the list daily with care plan updates when needed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all nurses, nurse aides, and medication tech□s and will be reviewed by the Quality Assurance process to verify that the change has been sustained. In-service education will continue until all required staff have been trained and staff will not be allowed to work after 10/08/2018 until training has been received. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will monitor the documentation of two person assistance provided for those residents requiring it by viewing the care task documentation and observations of 10 residents. The Quality Assurance tool will be completed weekly for 4 weeks then	

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F 656	Continued From page 15 #28 could partly help with repositioning in bed, therefore, one person could provide bed mobility. On 9/12/18 at 1:30 PM, during an interview, Nurse Aide #6 indicated that Resident #28 required one person for assistance with bed mobility. During an interview, the nurse aide logged in to the portable computer and found Resident 28 ' s assignment, showed two people assistance for bed mobility. She was not aware of this change in Point of Care. On 9/12/18 at 2:00PM, during an interview, the Corporate Nurse Consultant indicated that the nurse aides did not have access to the plan of care and followed point of care on portable computers. When plan of care updated, the point of care updated automatically. On 9/12/18 at 2:30PM, during an interview, the Director of Nursing (DON), expected the staff to follow resident ' s plan of care/point of care. The nurse aides could clarify it with the floor nurse if needed. The DON remembered that after Resident 28 ' s incident, the plan of care and point of care were updated to two people for assistance with bed mobility. It was nurse aides ' responsibility to follow the changes in point of care and document it appropriately.	F 656	monthly for 2 months. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager. The title of the person responsible for implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced	F 658		10/8/18

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F 658	Continued From page 16 by: Based on observation, record review and staff interviews, the facility failed to provide a physician order for oxygen administration for one of one resident reviewed for respiratory care (Resident #271). Findings included: Resident #271 was admitted 09/06/18 with diagnoses that included right-sided hemiplegia and hemiparesis following a cerebrovascular accident (CVA), frontal lobe and executive function deficit following a CVA, and enterocolitis due to Clostridium difficile (C. diff). The admission Minimum Data Set (MDS) was not yet completed at the time of the survey. Documentation of oxygen use was present in the following notes: The admission assessment dated 09/06/18 at 7:00 p.m. noted that Resident #271 arrived by ambulance from the hospital with oxygen delivered via nasal cannula. Daily nursing progress notes dated 09/07/18 to 09/11/18 noted that the resident continued to receive oxygen via nasal cannula. An evaluation by Respiratory Therapist #1 dated 09/10/18 noted that Resident #271 received oxygen via nasal cannula and that "1-3 liters of oxygen [were] required" by the resident to maintain an oxygen saturation rate above 92%. On 09/11/18 at 9:37 a.m., Resident #271 was observed in her room wearing a nasal cannula delivering oxygen.	F 658	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F658 Plan for correcting specific deficiency. The process that led to deficiency cited. The facility failed to provide a physician order for oxygen administration by one of one resident reviewed for respiratory care. On 9/12/18, the Unit Manager entered a physician order for oxygen administration and monitoring for resident #271. The nurse managers audited all current residents to establish which residents were receiving oxygen therapy. This was completed by observing each resident and their room for oxygen administration in place. Once it was determined who had oxygen, the physician orders were reviewed to ensure there was and order in place for oxygen administration and monitoring. If no orders were in place one was obtained. This will be completed by 10/08/2018.	

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F 658	Continued From page 17 There was no physician order for oxygen present in the medical record. In an interview on 09/12/18 at 11:09 a.m., Nurse Practitioner #1 acknowledged there was no order for oxygen for Resident #271. She further acknowledged that monitoring was necessary for continuous oxygen use by a resident, including the need for routine assessments of oxygen saturation. She stated that she considered it part of the routine admission procedure for the nurse to inform the medical provider of the use of supplemental oxygen. In an interview on 09/12/18 at 4:35 p.m., the Attending Physician stated his awareness of the need to place a physician order for oxygen use. He stated his expectation that the admitting nurse obtain the order when a resident was admitted from the hospital on oxygen. In an interview on 09/12/18 at 11:12 a.m., the Director of Nursing shared her expectation that oxygen use by residents was covered by a medical order and that its use was monitored for effectiveness.	F 658	Procedure for implementing the acceptable plan of correction. On 10/04/2018, the Nurse Consultant and or Director of Nursing provided an in-service education to all full time, part time, and as needed nurses and Medication Tech□s. Topics included: *Ensuring on admission and with changes in condition, if oxygen therapy is initiated that physician orders are obtained for oxygen administration and monitoring. *How to initiate Batch Orders for oxygen use and monitoring. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all nurses and medication tech□s and will be reviewed by the Quality Assurance process to verify that the change has been sustained. In-service education will continue until all required staff have been trained and staff will not be allowed to work after 10/08/2018 until training has been received. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will monitor the documentation of oxygen therapy and ensuring physician orders are obtained. The Quality Assurance tool will be completed weekly for 4 weeks then monthly for 2 months. Monitoring will	

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F 658	Continued From page 18	F 658	include auditing 100% of all new admissions for oxygen use and documentation. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager. The title of the person responsible for implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	
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 record reviews, resident and staff interviews, the facility failed to trim fingernails for 1 of 5 sampled residents (Resident's #11), who were dependent on staff for assistance with activities of daily livings (ADLs). Findings include:	F 677	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this	10/8/18

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F 677	Continued From page 19 Resident #11 was readmitted on 3/6/18. His diagnoses included dementia, Alzheimer disease and diabetes mellitus. Review of Resident #11's Quarterly Minimum Data Set, dated 6/25/18, revealed resident's cognition was severely impaired, and he required total assistance with ADLs, included nail care. Review of Resident 11 ' s plan of care, dated 6/11/18, revealed that he had ADL Self Care Performance Deficit, related to diagnoses of dementia, Alzheimer disease with appropriate goals and interventions. Record review of Resident 11 ' s care tracker for August - September 2018 revealed that his last fingernails trimming provided on 8/24/18. On 9/10/18 at 1:10 PM and 9/11/18 at 9:10 AM, during an observation/interview, Resident #11 was in his wheelchair, well dressed. His fingernails were about 8 mm (millimeter) beyond his fingertips on both hands. The resident did not have enough mental capacity to confirm his preferences for nail care. On 9/11/18 at 9:10 AM, during an interview, Nurse Aide #5 indicated that Resident #11 assigned to him this shift. The Nurse Aide confirmed that Resident 11 ' s fingernails looked long beyond his fingertips, but only nurses or podiatrist could cut nails for resident with diabetes mellitus. The Nurse Aide did not report long fingernails to the nurse on the floor. On 9/11/18 at 9:20 AM, during an interview, Nurse #3 indicated that Resident #11 had diagnosis of diabetes mellitus, and the nurses were responsible for trimming his fingernails. She	F 677	plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F677 Plan for correcting specific deficiency. The process that led to deficiency cited. The facility failed to trim fingernails for 1 of 5 sampled residents who were dependent on staff for assistance with activities of daily living. On 9/11/18 the Director of Nursing trimmed resident #11 fingernails. The nurse managers audited all current residents to establish which residents were in need of nail care. Once it was determined who needed nail care, the assigned nurses and nurse aides completed the nail care. This will be completed by 10/05/2018. Procedure for implementing the acceptable plan of correction. On 10/04/2018, the Nurse Consultant and or Director of Nursing began an in-service education to all full time, part time, and as needed nurses, CNA□s, and Medication Tech□s. Topics included: *Daily nail care policy NUP-550 *How to document that nail care was given *Nurse aides reporting nail care needs such as nails needing trimming to the nurse when noted	

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F 677	Continued From page 20 was not aware of Resident 11 ' s long fingernails. The nurse aides did not report it to her. The nurse confirmed that according to care tracker, last time resident ' s fingernails were trimmed on 8/24/18. On 9/11/18 at 9:30 AM, during an interview, the Director of Nursing expected the staff to provide assistance with ADLs, including nail care, per plan of care and as needed. For the residents with diabetes mellitus, the aides could clean and the nurses could trim fingernails. When residents needed nails ' trimming, the aides should report it to the floor nurse.	F 677	This information has been integrated into the standard orientation training and in the required in-service refresher courses for all nurses, CNA□s, and medication tech□s and will be reviewed by the Quality Assurance process to verify that the change has been sustained. In-service education will continue until all required staff have been trained and staff will not be allowed to work after 10/08/2018 until training has been received. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will monitor the nail care completion. The Quality Assurance tool will be completed weekly for 4 weeks then monthly for 2 months. Monitoring will include auditing 10 residents□ documentation and observing their nails for completion of nail care. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager. The title of the person responsible for	

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F 677	Continued From page 21	F 677	implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	