STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345526	A. BUILDING _____ B. WING _____	C 10/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA REHAB CENTER OF BURKE	3647 MILLER BRIDGE ROAD CONNELLY SPG, NC 28612

(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
E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to establish and maintain a comprehensive Emergency Preparedness Plan which described the facility's comprehensive approach to meeting the health, safety and security needs for their staff and resident population during an emergency or disaster situation. The findings included:	E 001	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s	10/26/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/24/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 001	Continued From page 1 Review of the Emergency Preparedness Plan manual provided by the facility with policies and procedures was conducted. The manual contained a template of how to organize the manual but did not contain written established policies and procedures or any individualized identification of staff and residents or duties of the management and staff in a disaster situation. The plan lacked the location to where residents would be sent and how the facility would communicate to others. During an interview on 10/04/18 at 5:52 PM, the Administrator stated that they failed to have a written individualized plan in place of the template in the Emergency Preparedness book.	E 001	allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. E001 How the corrective action will be accomplished for the resident(s) affected. A more specific emergency preparedness plan has been established by the facility to include, commander in charge is the Administrator, clinical commander in charge is the Director of Nursing, means of communications, the facility purchased walkie talkies for each of the Department Heads and Charge Nurses so that if communication by phones go down, communication between staff can continue without delay, evacuation sites in lieu of local emergency evacuation have been established by the Administrator to include two local location; along with two sister facilities should the local sites not be available, Storage Boxes have been utilized to store Forms that may be needed in the event that electronic medical records are not available and par levels are evaluated throughout each week to ensure adequate supplies are on hand at all times for residents, to also include a 7 day supply should an emergency take place. How corrective action will be accomplished for those residents with the potential to be affected by the same practice. To avoid any resident being affected by this, the facility will run on Mondays a RUG Summary so that the	

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E 001	Continued From page 2	E 001	Director of Nursing can follow the evacuation plan based on the following criteria in the order listed: 1) Reduced Physical Functioning, 2) Clinically Complex, 3) Special Care, 4) Extensive Services, 5) Rehabilitation, this would allow patients with low functioning to higher functioning being transferred out in that order. Measures in place to ensure practices will not re-occur. Emergency Manual has been tabbed out to follow the surveyor recommendations, specifics of the emergency plan have been established. These plans will be reviewed and updated annually and taken to QAPI annually or as needed to reflect any changes needed. Administrator will update the book with updated Staff Roster/Phone Numbers to also include a census sheet to identify residents in house. Also included in the book will be the patient Rug Summary on Mondays identifying patients acuity level thus knowing who must be transferred in order of importance/acuity.. An audit weekly will be posted by Administrator that the book is checked and the Nurse Consultant will check the book on visits and verify that the book has been checked. How the facility plans to monitor and ensure correction is achieved and sustained. Reviewed QAPI monthly to ensure the book is accurate and up to date and appropriate changes made if needed to ensure a complete Emergency Plan.	

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F 578	Continued From page 3	F 578		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he	F 578		10/26/18

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F 578	Continued From page 4 or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to ensure the Advanced Directive matched on the hard copy and the electronic record for 1 of 3 residents reviewed for code status (Resident #35). The findings included: Resident #35 was admitted to the facility on 01/20/15 and re-admitted on 08/22/18 with diagnoses of heart failure, neurogenic bladder, diabetes, non- Alzheimer's dementia, and respiratory failure. Review of the significant change Minimum Data Set (MDS) dated 08/31/18 revealed Resident #35 was severely cognitively impaired. Review of the care plan dated 09/07/18 revealed Resident #35 had a terminal prognosis related to congestive heart failure. Review of the physician orders dated 08/22/18 revealed Resident #35 was admitted to Hospice Services. Review of the profile sheet in the electronic record on 10/01/18, 10/02/18, 10/03/18 and 10/04/18 revealed Resident #35 was a full code status. Review of the hard copy Advanced Directive on 10/03/18 and 10/04/18 revealed Resident #35 was a Do Not Resuscitate code status.	F 578	F578 How the corrective action will be accomplished for the resident(s) affected. Resident #35 advance directive was updated on the electronic medical record to reflect accuracy of his MOST form on 10/04/2018. How corrective action will be accomplished for those residents with the potential to be affected by the same practice. The Staff Development Coordinator in-serviced/re-educated RN□s and LPN charge nurses on the requirement of advance directives and accuracy. The Director of Nursing or designee will complete 100% audit of all residents advance directives to ensure accuracy of forms and electronic medical record on 10/10/2018. No other discrepancies noted. Any nurse that is not trained will be removed from the schedule until training is complete and all new nurses will be educated on hire during orientation of this requirement. Measures in place to ensure practices will not re-occur. Measures put into place to ensure that the alleged deficient practices does not reoccur include: DON or designee will complete 100% audit of the	

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F 578	Continued From page 5 An interview conducted on 10/03/18 at 2:22 PM with Nurse #4 revealed she checked the code status for a resident from the hard copy on the desk but had never compared it to the code status on the electronic record. An interview conducted on 10/04/18 at 2:00 PM with the Director of Nursing revealed the Advance Directive should match on the hard copy and the electronic record. An interview conducted on 10/04/18 at 5:30 PM with the Administrator revealed it was her expectation for the Advance Directive on the hard copy and electronic record match.	F 578	advance directives hard copy and the electronic medical records once per week x 4 weeks on all records to include all new admissions and then monthly x 3 months of all. How the facility plans to monitor and ensure correction is achieved and sustained. The Director of Nursing will review data obtained during audits, concerns, and rounds; analyze the data and report patterns/ trends to the QAPI committee every month for 3 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions based on identified trends/ outcomes to ensure continued compliance.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss	F 584		10/26/18

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F 584	Continued From page 6 or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain a clean and sanitary environment for 3 of 4 halls (Rooms 104, 109, 209, 308, and 309) by keeping personal care equipment labeled and stored properly and maintaining a mold free shower stall in the upper 300 hall shower room. The findings included: 1. Resident personal care equipment was not labeled and stored to protect against contamination as follows: a. An observation of the shared bathroom for	F 584	F584 How the corrective action will be accomplished for the resident(s) affected. Personal items were labeled in rooms 104, 109, 209, 308, and 309 on 10/4/2018. The 300 hall shower room has be cleaned and the floors have been re-grouted on 10/15/2018. How corrective action will be accomplished for those residents with the potential to be affected by the same practice. All CNA□s and nurses were re-educated regarding the safety requirements of	

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F 584	Continued From page 7 contact isolation room 109 on 10/04/18 at 9:40 AM revealed an unlabeled bed pan hanging on a bathroom rail and unlabeled shampoo was sitting on the back of the toilet. An interview with the Administrator on 10/04/18 at 9:40 AM revealed she expected all personal care items to be labeled. b. An observation of the shared bathroom for contact isolation room 104 on 10/04/18 at 9:41 AM revealed an unlabeled hair brush, unlabeled toothbrush, unlabeled denture cup, and unlabeled denture paste were sitting on the side of the sink. An interview with the Administrator on 10/04/18 at 9:41 AM revealed she expected all personal care items to be labeled. c. An observation of the shared bathroom for room 209 on 10/04/18 at 9:53 AM revealed 2 unlabeled denture cups were sitting on the side of the sink. An interview with the Director of Nursing (DON) on 10/04/18 at 9:53 AM revealed it was her expectation that denture cups should have been labeled. d. An observation of the shared bathroom for room 308 on 10/04/18 at 9:58 AM revealed there were 2 unlabeled denture cups sitting on the side of the sink, 1 unlabeled travel toothbrush protector sitting on the side of the sink, and 2 bath pans labeled but stacked together and sitting on a wheelchair that was stored in the bathroom. An interview with the DON on 10/04/18 at 9:58 AM revealed the bath pans should have been	F 584	labeling personal care items and keeping them stored properly on 10/22/2018. Any nurse or CNA that is not trained will be removed from the schedule until training is complete and all new nurses will be educated on hire during orientation of this requirement. The Housekeeping Manager and staff were re-educated regarding the proper sanitation of the shower stall on 10/08/2018. Measures in place to ensure practices will not re-occur. An audit will be performed on 100% of patient rooms by department heads. Results will be discussed during weekly stand-up meetings Monday, Wednesday and Friday, specifically highlighting labeling and storage of personal care items, and the proper sanitation for all shower stalls Monday-Friday for 4 weeks and then monthly x 3 months. How the facility plans to monitor and ensure correction is achieved and sustained. The Director of Nursing will review data obtained during audits, concerns, and rounds; analyze the data and report patterns/ trends to the QAPI committee every month for 3 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions based on identified trends/ outcomes to ensure continued compliance.	

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F 584	Continued From page 8	F 584		

stored in separate bags and hung up in the bathroom but the wife (this room was shared by a husband and wife) requested nothing else be labeled.

e. An observation of the shared bathroom for room 309 on 10/04/18 at 10:00 AM revealed an unlabeled denture cup and a bottle of unlabeled perineal and skin cleanser sitting on top of the paper towel holder, an unlabeled bottle of perineal and skin cleanser sitting on the side of the sink, 2 unlabeled tubes of toothpaste and an unlabeled toothbrush sitting on the side of the sink, and an unlabeled tube of protective ointment sitting on top of the toilet.

An interview with the DON on 10/04/18 at 10:00 AM revealed the perineal and skin cleanser should have been labeled, the denture cup was not issued by the facility so it may not have been labeled, and the protective ointment should have been discarded after use.

2. An observation of the upper shower room of 300 hall on 10/02/18 at 11:22 AM revealed the second shower stall on the left had black, easily removed mold in the grout lines. The moldy build up remained in place in the shower stall when observed on 10/04/18 at 4:27 PM.

An interview with the Administrator on 10/04/18 at 4:27 PM revealed she felt the tile was discolored and that housekeeping cleaned the shower room daily.

An interview with the housekeeping supervisor on 10/04/18 at 4:32 PM revealed the shower room was mopped daily and as needed. The housekeeping supervisor also stated the shower

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F 584	Continued From page 9 rooms were deep cleaned monthly with disinfectant foam and the shower room had been deep cleaned last week.	F 584		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code 1 of 2 sampled residents (Resident #31) with skin integrity issues utilizing the Minimum Data Set (MDS) for coding for skin issues. The findings included: Resident #31 was admitted to the facility on 06/01/18 with diagnoses including hypertension (high blood pressure), diabetes, and difficulty walking. A quarterly MDS dated 08/29/18 indicated Resident #31 was coded under Section M-Skin Conditions as having an unhealed stage 3 pressure ulcer that was present on admission. A review of Resident #31's care plans revealed no care plan was present for having a pressure ulcer. An interview with the MDS Coordinator on 10/04/18 at 5:15 PM revealed that if a resident is coded as having a stage 3 pressure ulcer she would expect a care plan to be in place for having a pressure ulcer and that the care plan just got	F 641	F641 How the corrective action will be accomplished for the resident(s) affected. Resident #31 MDS was modified to include the accuracy of the wound stage and re-submitted on 10/8/2018. How corrective action will be accomplished for those residents with the potential to be affected by the same practice. Resident Assessment Director and MDS Coordinator have reviewed assessments of all residents with wound in the last 30 days to ensure coding accuracy. The Regional Data Analyst Verification Specialist (DAVS) re-educated the Resident Assessment Director and Coordinators on RAI manual guidelines on 10/23/2018 regarding completion and accuracy of assessments. The Regional Data Analyst Verification Specialist and Resident Care Management Director will validate accuracy of MDS submitted on 10/08/2018 and	10/26/18

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F 641	Continued From page 10 overlooked. An interview with the Director of Nursing (DON) on 10/04/18 at 5:53 PM revealed the MDS was coded incorrectly. The DON stated Resident #31 did not have a stage 3 pressure ulcer and it was more of a wound from moisture associated dermatitis. The DON stated it was her expectation that the MDS would be coded accurately to reflect Resident #31 did not have a stage 3 pressure ulcer. The DON also stated the MDS would require a correction to reflect Resident #31 did not have a stage 3 pressure ulcer.	F 641	modify any changes needed according to findings by 10/8/2018. Measures in place to ensure practices will not re-occur. The Regional DAVS has conducted In-service/re-education for the Resident Care Management Director, MDS Coordinator, on 10/23/2018 regarding how to perform proper assessment, MDS Accuracy, and proper coding as described in the RAI Manual. Resident Assessment Director and MDS Coordinator have reviewed all wound assessments completed in the last 30 days to ensure coding accuracy. The Resident Assessment Director will audit 10 wound assessments per month for 3 months to ensure accurate coding. How the facility plans to monitor and ensure correction is achieved and sustained. The Resident Care Management Director and Director of Nursing will review data obtained during assessment Audits, analyze the data and report patterns/ trends to the QAPI committee every month x 3month. The QAPI committee will evaluate the effectiveness of the above plan, and will add interventions based on Identified trends/ outcomes to ensure continued compliance.	
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,	F 658		10/26/18

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F 658	Continued From page 11 must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to transcribe physician orders for Vitamin B12 injections correctly for 1 of 5 sampled residents reviewed for unnecessary medications. This resulted in Resident #60 receiving an unneeded injection. The findings included: Resident #60 was admitted to the facility on 01/24/18. Her diagnoses included atrial fibrillation, chronic obstructive pulmonary disease, kidney disorder, anxiety disorder and major depressive disorder. Review of the medical record revealed Resident #60 saw the oncologist on 07/23/18. At that visit the oncologist ordered Vitamin Deficiency System B 12 Kit 1000 mcg/mg (microgram/milligrams) inject 1 ml (milliliter) intramuscularly once a week for 4 weeks then change to monthly. Review of the Medication Administration Records (MAR) for August 2018 revealed the B 12 injection was administered weekly on 08/01/18, 08/08/18, 08/15/18 and on 08/22/18. The MAR for September 2018 revealed the B 12 injection was listed on the MAR twice as follows: *Vitamin Deficiency System B 12 Kit 1000 mcg/ml inject 1 ml intramuscularly one time every 30 days with an order date of 07/25/18; and immediately below: *Vitamin Deficiency System B 12 Kit 1000 mcg/ml inject 1 ml intramuscularly one time every 30 days	F 658	F658 How the corrective action will be accomplished for the resident(s) affected. Resident #60 orders for Vitamin B12 injection were updated to reflect accuracy of current order on 10/04/18. How corrective action will be accomplished for those residents with the potential to be affected by the same practice. The Staff Development Coordinator in-serviced/re-educated RN□s and LPN charge nurses on the requirement of accuracy of order transcription. Any nurse that is not trained will be removed from the schedule until training is complete and all new nurses will be educated on hire during orientation of this requirement. The Director of Nursing or designee completed 100% audit of all orders and accuracy and electronic medical record updated on 10//10/2018. All new hire Nurses will be oriented in orientation regarding order accuracy. Measures in place to ensure practices will not re-occur. 100% audit to be completed once per week x 4 weeks and then monthly x 3 months for all patients receiving B12 injections to ensure that overlapping orders do not exist and the orders transcribed correctly.	

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F 658	Continued From page 12 with an order date of 07/23/18. The MAR revealed the B 12 injection was given on 09/21/18 and on 09/22/18, by 2 different nurses. Review of the current physician orders for October 2018 located in the computer revealed Vitamin B 12 was listed to be given twice during the month. The MAR for October 2018 had the two separate orders for B 12 injections listed to be given on 10/21/18 and 10/22/18. An interview with the Director of Nursing (DON) revealed the order originated on 07/23/18 for B 12 injections to be given weekly for 4 weeks then monthly. She stated that it appeared two staff put this order in on two separate days resulting in the order reading for the 21st and 22nd after the initial 4 weeks. She stated she thought this was a breakdown in the computer system as the computer should have caught the mistake. The DON stated they were checking orders daily to ensure the paper orders were in the computer but had not been comparing the orders to the MARs.	F 658	How the facility plans to monitor and ensure correction is achieved and sustained. The Director of Nursing will review data obtained during audits, concerns, and rounds; analyze the data and report patterns/ trends to the QAPI committee every month for 3 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions based on identified trends/ outcomes to ensure continued compliance.	
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.	F 695		10/26/18

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F 695	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews the facility failed to obtain oxygen orders for the rate of administration for 2 of 6 residents reviewed with oxygen (Resident #8 and #59). The findings included: 1. Resident #8 was admitted to the facility on 07/07/18 with diagnoses of heart failure, diabetes, respiratory failure and muscular dystrophy. Review of the quarterly Minimum Data Set (MDS) dated 07/20/18 revealed Resident #8 was cognitively intact and required the use of oxygen. Review of the care plan dated 07/31/18 revealed Resident #8 had congestive heart failure with a goal to have clear lung sounds, heart rate and rhythm within normal limits through the next review date. The interventions included oxygen as ordered. Review of the physician orders revealed no order for oxygen use. Observations made on 10/02/18 at 1:53 PM, 10/03/18 at 10:00 AM and 10/03/18 at 3:55 PM revealed Resident #8 to be receiving oxygen via nasal cannula at 3 liters per minute. An interview conducted on 10/01/18 at 11:02 AM with Resident #8 revealed she receives oxygen 24 hours a day via nasal cannula at 3 liters per minute. An interview conducted on 10/04/18 at 3:55 PM	F 695	F695 How the corrective action will be accomplished for the resident(s) affected. Resident #8 and #59 oxygen orders were updated on 10/03/2018 in the orders for each resident in the electronic medical record to reflect accuracy of oxygen orders. How corrective action will be accomplished for those residents with the potential to be affected by the same practice. The Staff Development Coordinator in-serviced/re-educated RN□s and LPN charge nurses on the requirement of complete oxygen orders on 10/25/2018. Any nurse or CNA that is not trained will be removed from the schedule until training is complete and all new nurses will be educated on hire during orientation of this requirement. The Director of Nursing or designee completed 100% audit of all residents on oxygen on 10/03/2018 and electronic medical record updated. No other discrepancies noted. Measures in place to ensure practices will not re-occur. An audit will be performed on 100% of new patients (admissions) to ensure that oxygen orders are transcribed onto the MAR. Results will be discussed during weekly stand-up meetings, specifically discussing new admissions that require oxygen administration Monday-Friday for 4 weeks and then	

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F 695	Continued From page 14 with the Director of Nursing revealed it was her expectation for all residents receiving oxygen to have a physician order for the rate of administration for the oxygen. 2. Resident #59 was admitted to the facility on 07/05/17 with diagnoses including heart failure, diabetes, chronic obstructive pulmonary disease (COPD), and difficulty walking. A review of the quarterly Minimum Data Set (MDS) dated 09/14/18 revealed Resident #59 received oxygen therapy. A review of the care plan for Resident #59 last updated 09/26/18 revealed she received oxygen therapy. A review of Physician orders on 10/02/18 for Resident #59 revealed there was no order for oxygen therapy. An observation of Resident #59 on 10/02/18 at 11:11 AM revealed she had oxygen in place at 3 liters/minute via nasal cannula. An observation of Resident #59 on 10/03/18 at 12:34 PM revealed she had oxygen in place at 3 liters/minute via nasal cannula. An observation of Resident #59 on 10/04/18 at 8:57 AM revealed she had oxygen in place at 3.5 liters/minute via nasal cannula. An interview with the Director of Nursing (DON) on 10/04/18 at 3:20 PM revealed Resident #59 did have an order at one time for oxygen at 2 liters/minute but that she had been sick recently and had some changes with her oxygen orders.	F 695	monthly x 3 months. How the facility plans to monitor and ensure correction is achieved and sustained. The Director of Nursing will review data obtained during audits, concerns, and rounds; analyze the data and report patterns/ trends to the QAPI committee every month for 3 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions based on identified trends/ outcomes to ensure continued compliance.	

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F 695	Continued From page 15 The DON stated her expectation was for every resident receiving oxygen therapy to have a Physician's order for oxygen therapy and for the oxygen concentrator to be set on the correct amount of oxygen ordered.	F 695		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 756		10/26/18

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F 756	Continued From page 16 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and pharmacist interview, the facility's pharmacist failed to identify an irregularity for 1 of 5 sampled residents reviewed for unnecessary medications. Resident #60's monthly B 12 injection was entered into the computer twice instead of once and this error was not identified by the pharmacist during his 09/28/18 review. The findings included: Resident #60 was admitted to the facility on 01/24/18. Her diagnoses included atrial fibrillation, chronic obstructive pulmonary disease, kidney disorder, anxiety disorder and major depressive disorder. Review of the medical record revealed Resident #60 saw the oncologist on 07/23/18. At that visit the oncologist ordered Vitamin Deficiency System B 12 Kit 1000 mcg/mg (microgram/milligrams) inject 1 ml (milliliter) intramuscularly once a week for 4 weeks then change to monthly. Review of the Medication Administration Records (MAR) for August 2018 revealed the B 12 injection was administered weekly on 08/01/18, 08/08/18, 08/15/18 and on 08/22/18. The MAR for September 2018 revealed the B 12	F 756	F756 How the corrective action will be accomplished for the resident(s) affected. Resident #60 had already received the dose, the Physician and Nurse Practitioner were aware that the patient received two doses of Vitamin B12, the order for the second B12 had been discontinued. How corrective action will be accomplished for those residents with the potential to be affected by the same practice. All patients that are receiving B12 injections were checked to ensure that there were no other instances of a patient having an order entered twice 10/25/2018. / Measures in place to ensure practices will not re-occur. The pharmacy consultant was educated and shown by the Director of Nursing how to look at the EMAR when doing his monthly medication reviews on 10/17/2018. He will be looking to ensure that there are no duplicate orders and Director of Nursing or designees will be reviewing orders daily to ensure that there are no duplicate orders.	

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F 756	Continued From page 17 injection was listed on the MAR twice as follows: *Vitamin Deficiency System B 12 Kit 1000 mcg/ml inject 1 ml intramuscularly one time every 30 days with an order date of 07/25/18; and immediately below: *Vitamin Deficiency System B 12 Kit 1000 mcg/ml inject 1 ml intramuscularly one time every 30 days with an order date of 07/23/18. The MAR revealed the B 12 injection was given on 09/21/18 and on 09/22/18, by 2 different nurses. Review of the Consultation Report from the pharmacist for his monthly medication review revealed nothing related to the B 12 injection being given twice during September 2018. Review of the current physician orders for October 2018 located in the computer revealed Vitamin B 12 was listed to be given twice during the month. The MAR for October 2018 had the two separate orders for B 12 injections listed to be given on 10/21/18 and 10/22/18. An interview with the Director of Nursing (DON) revealed the order originated on 07/23/18 for B 12 injections to be given weekly for 4 weeks then monthly. She stated that it appeared two staff put this order in on two separate days resulting in the order reading for the 21st and 22nd after the initial 4 weeks. She stated she thought this was a breakdown in the computer system as the computer should have caught the mistake. The DON stated they were checking orders daily to ensure the paper orders were in the computer but had not been comparing the orders to the MARs.	F 756	How the facility plans to monitor and ensure correction is achieved and sustained. The Administrator and Director of Nursing will review data obtained during audits; analyze the data and report patterns/ trends to the QAPI committee every month for 3 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions based on identified trends/ outcomes to ensure continued compliance.	

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F 756	Continued From page 18 Follow up interview with the DON on 10/04/18 at 3:08 PM, revealed she would have expected the double order of B 12 injection to be identified and reported to the facility by the pharmacist. A telephone interview on 10/04/18 at 3:53 PM with the pharmacist revealed he did not check the MARs as he did not think he had access to the facility's documentation. Per his access, Vitamin B 12 was listed to be given on the 22nd of each month.	F 756		
F 804 SS=D	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 resident interview, staff interviews and recipe review, the facility failed to follow the recipe of a planned menu item resulting in 1 of 1 sampled resident with a food allergy receiving food to which he was allergic. (Resident #282). The findings included: Resident #282 was admitted to the facility on 09/20/18. The medical record had a list of allergies dated 09/20/18 which indicated Resident #282 was allergic to mushrooms which would result in a severe anaphylaxis reaction.	F 804	F804 How the corrective action will be accomplished for the resident(s) affected. Resident #282 dietary ticket was updated on 10/1/2018 to include his food allergies. How corrective action will be accomplished for those residents with the potential to be affected by the same practice. The Corporate Dietitian and facility Registered Dietitian in-serviced/re-educated dietary staff on	10/26/18

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F 804	Continued From page 19 The Minimum Data Set, an admission dated 09/27/18, coded him as having intact cognitive skills. During an interview on 10/01/18 at 3:04 AM, Resident #282 stated that Thursday or Friday of the previous week he received mushrooms on his meat. On 10/01/18 at 3:10 PM Resident continued and expressed concern that he had received mushrooms after the first day of admission and at that time he told staff he was allergic to mushrooms. On 10/02/18 at 2:18 PM, Resident #282 stated he received mushrooms on his tray the previous evening. He stated he did not eat them but was upset and he felt it almost caused him a seizure. Review of the tray slip sent on the dinner tray on 10/01/18 revealed no allergies were listed and he received beef tips and spinach Toscana. Review of the recipes for both the beef tips and the spinach revealed that neither recipe called for mushrooms. On 10/02/18 at 2:23 PM, the Dietary Manager stated during interview that when a resident was admitted to the facility, he received a diet slip for the new resident. DM stated no one received a tray without a diet slip. DM reported that Resident #282's diet slip did not list any food allergies. DM stated that mushrooms were in the spinach Toscana last evening. He also stated mushrooms were in the pork cacciatore stew last Friday. DM stated that he was informed yesterday around lunch that he was allergic to mushrooms. He stated he updated the computer about the resident's allergy to mushrooms and	F 804	the requirement of following the menu and standardized recipes; to include residents not to receiving foods of which they are allergic to 10/22/2018. This training included the process for monitoring tickets, correctly following standardized recipes and updating allergies as needed. Measures in place to ensure practices will not re-occur. The Dietary Manager will complete an audit of all residents trays to ensure recipe compliance and exclusion of food allergies as indicated. The Dietitian conducted an in-service/re-education on requirements to follow the recipe for the meal being served. This training included the process of monitoring dietary communication slips for allergies and the importance of following standardized recipes to ensure residents are not being served foods they are allergic too. The training occurred on 10/22/2018. The Dietary Manager, will audit 6 random resident trays weekly x 4 weeks, then 6 random trays every other week x 3 months to ensure standardized recipes were followed and do not include resident allergens. How the facility plans to monitor and ensure correction is achieved and sustained. The Administrator and Director of Nursing, and Dietary Manager will review data obtained during audits, concerns, and rounds; analyze the data and report patterns/ trends to the QAPI committee every month for 3 months. The QAPI committee will evaluate the effectiveness of the above plan, and will	

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F 804	Continued From page 20 then reprinted the evening meal tickets. He stated that per the recipes, the computer will automatically remove any items that will have the food item in it that residents are allergic to. He was informed this morning that Resident #282 received the mushrooms last evening. He stated he did not know what happened and thought there was a cliche in the computer system. Then on 10/02/18 at 2:40 PM the DM stated he checked the pork recipe and no mushrooms were to be added to that meal. On 10/02/18 at 2:45 PM, Nurse #1 was interviewed by phone. She stated that last week she had noticed a nurse aide remove a tray from Resident #282's room and told her he was allergic to mushrooms. She thought the nurse aide reported it to the dietary department. On 10/02/18 at 2:49 PM, the cook was interviewed. She stated she cooked and served last evenings dinner. She stated the tray card did not list mushrooms as an allergy. The cook stated the tray came back last evening and she wrote across the tray card that Resident #282 was allergic to mushrooms and laid it on the Dietary Manager's desk to make sure he was aware of the allergy. The cook then stated that the spinach recipe did not call for mushrooms, but she took it upon herself to add cream of mushroom soup to give it added flavor. She stated she did not add mushrooms to the pork last week. On 10/02/18 at 3:08 PM, the Administrator stated she had heard rumors about Resident #282 having received food he was allergic to last week and she had a 100% audit completed yesterday afternoon to ensure all food allergies were	F 804	add additional interventions based on identified trends/ outcomes to ensure continued compliance. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions based on identified trends/ outcomes to ensure continued compliance.	

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F 804	Continued From page 21 identified. She was brought Resident #282's tray last night and informed of the mushroom allergy. She provided evidence that the computer had been updated with this allergy on 10/01/18 at 1:40 PM. Review of this computer activity log revealed that mushrooms were listed as an allergy on 09/20/18 at 12:25 PM. The Administrator stated she believed the Dietary Manager did not reprint the dinner tray cards after the audit. The Administrator stated Resident #282 should not have received mushrooms on his tray. Interview with Nurse #2 via phone on 10/02/18 at 4:01 PM revealed she took the tray of last evening to the kitchen. The tray card was silent to mushrooms being an allergy for Resident #282. She stated she observed no reaction for the mushrooms being on his plate. Nurse #3 was interviewed on 10/02/18 at 4:07 PM. She stated she worked with Resident #282 last evening after hearing he had received mushrooms that he was allergic to. She stated he was scared and his voice quivered so she calmed him by talking to him for awhile. He had no physical reaction.	F 804		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a	F 806		10/26/18

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F 806	Continued From page 22 different meal choice; This REQUIREMENT is not met as evidenced by: Based on record review, resident interview and staff interviews, the facility failed to ensure 1 of 1 sampled resident with a food allergy did not receive food to which he was allergic. (Resident #282). The findings included: Resident #282 was admitted to the facility on 09/20/18. The medical record had a list of allergies dated 09/20/18 which indicated Resident #282 was allergic to mushrooms which would result in a severe anaphylaxis reaction. Review of the dietary computer activity log, mushrooms were listed as an allergy for Resident #282 on 09/20/18 at 12:25 PM. The Minimum Data Set, an admission dated 09/27/18, coded him as having intact cognitive skills. During an interview on 10/01/18 at 3:04 AM, Resident #282 stated that Thursday or Friday of the previous week he received mushrooms on his meat. On 10/01/18 at 3:10 PM Resident continued and expressed concern that he had received mushrooms after the first day of admission and at that time he told staff he was allergic to mushrooms. On 10/02/18 at 2:18 PM, Resident #282 stated he received mushrooms on his tray the previous evening, 10/01/18. He stated he did not eat them but was upset and he felt it almost caused him a seizure.	F 806	F806 How corrective action will be accomplished for each resident found to have been affected by the deficient practice Resident #282 meal ticket was updated to reflect the allergy and was checked by the Regional Dietician to ensure that it reflected the allergy. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice The Regional Dietary Manager/Registered Dietician in-serviced/re-educated dietary staff on the requirement of adding and printing new dietary slips when they are notified of a patients food allergy to ensure that the resident does not receive foods of which they are allergic to. This training included the process for monitoring tickets and updated allergies and printing new tickets when allergies are identified and added to the dietary slip and completed 10/22/2018. The Staff Development Coordinator educated Nursing staff on completing Dietary Communication Form and hand delivering the form to the Lead Cook or Dietary Manager. Measures to be put in place or systemic changes made to ensure practice will not Re-occur- Weekly x 3 months, during daily standup meetings (Mon-Fri) the Director of Nursing or designee will review	

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	345526	A. BUILDING _____ B. WING _____	C 10/04/2018

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F 806	Continued From page 23 Review of the tray slip sent on the dinner tray on 10/01/18 revealed no allergies were listed and he received beef tips and Spinach Toscana. Review of the recipes for both the beef tips and the spinach revealed that neither recipe called for mushrooms. On 10/02/18 at 2:23 PM, the Dietary Manager stated during interview that when a resident was admitted to the facility, he received a diet slip for the new resident. DM stated no one received a tray without a diet slip. DM reported that Resident #282's diet slip did not list any food allergies. DM stated that mushrooms were in the spinach Toscana last evening. He also stated mushrooms were in the pork cacciatore stew last Friday. DM stated that he was informed yesterday around lunch that he was allergic to mushrooms. He stated he updated the computer about the resident's allergy to mushrooms and then reprinted the evening meal tickets. He stated that per the recipes, the computer will automatically remove any items that will have the food item in it that residents are allergic to. He was informed this morning that Resident #282 received the mushrooms last evening. He stated he did not know what happened and thought there was a cliche in the computer system. Then on 10/02/18 at 2:40 PM the DM stated he checked the pork recipe and no mushrooms were to be added to that meal. On 10/02/18 at 2:45 PM, Nurse #1 was interviewed by phone. She stated that last week she had noticed a nurse aide remove a tray from Resident #282's room and told her he was allergic to mushrooms. She thought the nurse aide reported it to the dietary department.	F 806	new or updated dietary slips brought to the stand-up meeting by the Dietary Manager or designee with a print out of current patients and allergies to ensure they are accurate with the patients food allergies, based on dietary slips, to ensure changes have been made in the tray card system. The Dietary Manager will complete an audit of all residents trays to ensure recipe compliance and exclusion of food allergies as indicated. How the facility plans to monitor and ensure correction is achieved and sustained. The Administrator and Director of Nursing, and Dietary Manager will review data obtained during audits, concerns, and rounds; analyze the data and report patterns/ trends to the QAPI committee every month for 3 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions based on identified trends/ outcomes to ensure continued compliance.	

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F 806	Continued From page 24 On 10/02/18 at 2:49 PM, the cook was interviewed. She stated she cooked and served last evenings dinner. She stated the tray card did not list mushrooms as an allergy. The cook stated the tray came back last evening and she wrote across the tray card that Resident #282 was allergic to mushrooms and laid it on the Dietary Manager's desk to make sure he was aware of the allergy. The cook then stated that the spinach recipe did not call for mushrooms, but she took it upon herself to add cream of mushroom soup to give it added flavor. She stated she did not add mushrooms to the pork last week. On 10/02/18 at 3:08 PM, the Administrator stated she had heard rumors about Resident #282 having received food he was allergic to last week and she had a 100% audit completed yesterday afternoon to ensure all food allergies were identified. She was brought Resident #282's tray last night and informed of the mushroom allergy. She provided evidence that the computer had been updated with this allergy on 10/01/18 at 1:40 PM. Review of this computer activity log revealed that mushrooms were listed as an allergy on 09/20/18 at 12:25 PM. The Administrator stated she believed the Dietary Manager did not reprint the dinner tray cards after the audit. The Administrator stated Resident #282 should not have received mushrooms on his tray. Interview with Nurse #2 via phone on 10/02/18 at 4:01 PM revealed she took the tray of last evening to the kitchen. The tray card was silent to mushrooms being an allergy for Resident #282. She stated she observed no reaction for the mushrooms being on his plate.	F 806		

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F 806	Continued From page 25 Nurse #3 was interviewed on 10/02/18 at 4:07 PM. She stated she worked with Resident #282 last evening after hearing he had received mushrooms that he was allergic to. She stated he was scared and his voice quivered so she calmed him by talking to him for awhile. He had no physical reaction.	F 806		
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 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	F 880		10/26/18

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F 880	Continued From page 26 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 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 observations and staff interviews the	F 880	F880	

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F 880	Continued From page 27 facility staff failed to wear gloves when checking the finger-stick blood glucose for 1 of 2 residents (Resident #49) observed during medication pass and failed to wear gloves for subcutaneous administration (an injection) of insulin for 1 of 2 residents (Resident #49). The findings included: A review of the facility's policy titled "Glucometer Cleaning-Infection Prevention Policy Single Patient Glucometers" developed 09/20/18 read in part, "At the time of obtaining the blood sugar the nurse will don gloves." An observation on 10/02/18 at 3:57 PM revealed Nurse #5 checked the finger-stick blood glucose of Resident #49 with no gloves in place. Nurse #5 then administered ordered insulin subcutaneously in Resident #49's right upper arm with no gloves in place. An interview on 10/02/18 at 4:03 PM with Nurse #5 revealed he did not wear gloves when checking the finger-stick blood glucose of Resident #49 and when administering insulin to Resident #49. Nurse #5 stated he should have had gloves on when checking the finger-stick blood glucose and when administering insulin for Resident #49. An interview on 10/02/18 at 4:11 PM with the Director of Nursing (DON) revealed that it was her expectation for all nurses to wear gloves when checking a finger-stick blood glucose and when administering insulin.	F 880	How the corrective action will be accomplished for the resident(s) affected. A Nurse failed to wear gloves while performing an accu-check and administering an insulin injection to resident #49. The Nurse was immediately removed from the assignment post incident and suspended pending termination of employment. How corrective action will be accomplished for those residents with the potential to be affected by the same practice. The Staff Development Coordinator in-serviced/re-educated RN□s and LPN charge nurses on the requirement of infection control measures regarding checking blood sugars and administering injections and observed return skill demonstration and/or by repeating proper infection control steps of checking accu-checks and administering injections by phone on 10/12/2018. Any active nurse who does not receive this education and return demonstration will not be allowed to work until completed. Measures in place to ensure practices will not re-occur. Staff Development Coordinator will complete five (5) Medication Pass Observations a week observing five (5) different nurses, not repeating nurses until all nurses have been observed. This will be completed until all nurses have been observed and then two (2) Medication Observations a week for a period of three months. All	

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F 880	Continued From page 28	F 880	new nursing hires will be oriented and required to have a Medication Pass Observation completed before being assigned on the unit. How the facility plans to monitor and ensure correction is achieved and sustained. The Director of Nursing will review data obtained from Medication Pass Observation Forms; analyze the data and report patterns/ trends to the QAPI committee every month for 3 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions based on identified trends/ outcomes to ensure continued compliance.	