STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345186	A. BUILDING ______ B. WING ______	C 10/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS MANOR	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

(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 interviews, the facility failed to review and maintain a comprehensive Emergency Preparedness (EP) plan. The facility failed to maintain and update the EP plan, update for current contacts, address resident population, address EP collaboration, collaborate with local stakeholders, review and update risk assessment, address subsistence for staff, address evacuation for staff, address medical records, address volunteers, update or review for arrangements with other facilities,	E 001	This plan of correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that deficiencies exist or that one was cited correctly. The plan of correction is submitted to meet requirements established by federal and state law. E 001 Establishment of the Emergency	11/8/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 11/02/2018

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 and update the communication plan, update names and contact information, address alternative means for communications, establish methods for sharing information or medical documentation, share information on facility occupancy, share information with residents or family members, put into place EP training and testing plans, conduct and put into place EP testing and simulation, document information in the EP regarding the emergency generator, and address integrated health systems policies and procedures. Findings included: A review completed of the facility's Emergency Preparedness plan material on 10/10/18 revealed: A. The EP plan was not maintained and had not been reviewed or updated annually. The current Administrator or the current Director of Nursing were not listed in the EP plan. B. The EP plan was not updated for current contacts. C. The EP plan did not address the resident population including at-risk residents and the type of services the facility could provide in an emergency. D. The EP plan did not address the procedures for EP collaboration with local, tribal, regional, state and Federal EP officials. E. Policies and procedures regarding the EP plan policies and procedures, based on the emergency plan for risk assessment and the	E 001	Program 1.No residents were named in the citation 2.Evacuation Plan (EP) to be updated completely, specifically the following areas: A. The current Administrator or the current Director of Nursing listed in the EP plan. Plan will be reviewed an updated annually and as needed by the Safety Committee. B. Current contacts updated C. Identification of the resident population including at-risk residents and the type of services the facility can provide in an emergency. D. Procedures for Evacuation Plan collaboration with local, regional, state and Federal EP officials. E. Policies and procedures (P & P) regarding the EP plan policies and procedures reviewed and will be reviewed annually and as needed with P & P changes. F. Policies and procedures subsistence for staff. G. Policies and procedures for tracking staff. H. Policies and procedures for evacuation of staff. I. Policies and procedures for medical records.	

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E 001	Continued From page 2 communication plan were not reviewed and updated annually. F. The EP plan did not address policies and procedures subsistence for staff. G. The EP plan did not address procedures for tracking staff. H. The EP plan did not address policies and procedures for evacuation of staff. I. The EP plan did not address policies and procedures for medical records. J. The EP plan did not address policies and procedures for volunteers. K. The EP plan was not currently updated or reviewed for arrangements with other facilities. L. The EP plan for communication was not current, reviewed, nor updated. M. The names and contact information were not current, reviewed, nor updated which were contained in the EP plan. N. The names and contact information contained in the EP plan for emergency officials contact information was not reviewed or updated. O. The EP plan did not address alternative means for communications. P. The EP plan did not establish methods for sharing information or medical documentation for the residents of the facility to maintain continuity of care.	E 001	J. Policies and procedures for volunteers. K. EP updated or reviewed for arrangements with other facilities. L. Update EP plan for communication and review with Safety Committee. M. Update contact information and review with Safety Committee N. Update and review contact information contained in the EP plan for emergency officials O. Identify alternative means for communications. P. Establish methods for sharing information or medical documentation for the residents of the facility to maintain continuity of care. Q. Establish sharing information on the facility occupancy or needs. R. Identify methods in place for sharing information from the emergency plan with residents or family members. S. Develop and put into place EP training and testing plans. T. Conduct EP testing and simulation exercises and establish testing schedule. U. Identify the emergency generator location, inspection, testing, and fuel.	

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E 001	Continued From page 3 Q. The EP plan did not establish sharing information on the facility occupancy or needs. R. The EP plan did not establish no methods in place for sharing information from the emergency plan with residents or family members. S. The facility failed to develop and put into place EP training and testing plans. T. The facility failed to conduct and put into place EP testing and simulation exercises. U. The EP plan lacked information regarding the emergency generator location, inspection, testing, and fuel. V. The EP plan failed to address integrated health system policies and procedures. An interview was conducted with the Administrator on 10/10/18 at 10:28 AM. The Administrator stated back in September the Hurricanes/High Winds Operational Procedures were reviewed in preparation for Hurricane Florence. The Administrator stated the Hurricanes/High Winds procedures were separate from the EP plan. The Administrator stated the EP plan had been reviewed in the Safety Committee meeting in September but there were no changes made to the EP plan during the meeting. The Administrator stated the contact people and contact information in the EP plan had not been updated. The Administrator stated the EP plan had not been updated for the current administrator or the current Director of Nursing, or their contact information. The Administrator further stated the EP plan had not been updated for: the current department head	E 001	V. Identify integrated health system policies and procedures. 3.Evacuation Plan will be reviewed and approved by Facility Safety Committee and reviewed annually with committee. Administrator will update changes to Evacuation Plan Specifics as they change throughout the year. 4.Updated Evacuation Plan will be reviewed with Quality Assurance Process Improvement (QAPI) Committee and any updates will be reviewed/approved by QAPI Committee as they arise.	

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E 001	Continued From page 4 list, current department head contact information, and the succession of command. The Administrator stated he had not had a meeting with facility/community stakeholders such as: The Durable Medical Equipment (DME) supplier, food supplier, the local fire department, the local police department, and had not conducted an evacuation drill or table top exercise. The Administrator stated the EP plan needed to be reviewed, updated, and maintained.	E 001		
F 000	INITIAL COMMENTS An unannounced recertification/complaint investigation was conducted 10/7/18 through 10/11/18.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the	F 550		11/8/18

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provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on record review, staff interview and observation the facility failed to respond to Resident #297 when she was calling out for food. Resident #297 was 1 of 1 residents reviewed for dignity issues.

Findings included:

Resident #297 was admitted to the facility on 10/1/18 with diagnoses of multiple rib fractures, repeated falls, dementia and psychosis. A review of her initial care plan dated 10/1/18 revealed she did not have a care plan for behaviors or calling out.

An observation on 10/8/18 at 8:33 am revealed the resident breakfast meal trays were delivered to the 400 Hall.

F 550

This plan of correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that deficiencies exist or that one was cited correctly. The plan of correction is submitted to meet requirements established by federal and state law.

F550 Dignity
1. Certified nursing assistant caring for resident #297 was immediately educated by Assistant Director of Nursing (ADON) on October 9th, 2018 regarding dignity for all residents during meal time.

2. No other residents were affected by

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During an observation of Resident #297 on 10/8/18 at 8:44 am she was sitting in a reclining chair in the hallway at the nurses' station. She yelled out, "I want to eat, I want to eat now."

During an observation on 10/8/18 at 8:45 am Resident #297 yelled out, "please just hurry up". Nurse #1 was at the desk at the time and stated, "She yells out all the time, even at night. That's just her." Nurse #1 continued to work at the nurses' desk and within 20 feet of the resident at her medication cart.

During an observation on 10/8/18 at 8:52 am a staff member moved Resident #297 in her reclining chair to the family room across from the 400 Hall Nurses' Station. The staff member did not acknowledge Resident #297 was calling out for food.

During an observation of Resident #297 on 10/8/18 at 8:58 am she yelled out, "I'm hungry, I'm hungry. I'll eat anything, hurry up." Resident #297 could be heard from the nurses' desk and the hallway. There were three staff members passing breakfast meal trays and walking up and down the hallways.

During an observation at 9:03 am on 10/8/18 a Nurse Aide #1 brought Resident #297's tray to her and stated, "Are you ready for breakfast?"

During an interview with the Unit Manager #1 on 10/9/18 at 4:15 pm she stated the meal trays are passed to the residents that do not need assistance first and then the residents that require assistance receive their meal trays.

F 550

the practice. Any residents asking for food or sleeping at meal times will be immediately accommodated during the dining process. Assistant Director of Nursing (ADON) began in-service education on October 9th, 2018 on the dining process to immediately accommodate residents requesting food at any time, for direct care staff which include; certified nursing assistants, licensed nursing staff, restorative staff, nurse managers, kitchen staff, and Guardian Angel team.

3. Effective November 8th, 2018 the following audits will be completed: Risk Manager (RM) will be assigned to monitor timely tray distribution on alternating halls and alternating meals for proper set up, residents needing Activities of Daily Living (ADL) assistance/sleeping on the nursing units three times weekly for 3 months to ensure solutions are sustained and report to Quality Assurance Performance Improvement (QAPI). Nurse assigned to the dining room will monitor for the same timeliness, set up, and assistance three times a week for 3 months to ensure solutions are sustained and report to QAPI. Guardian Angel Program at Five Oaks Manor is a customer service program where department heads are assigned to residents to perform daily rounds to ensure quality service provision. Beginning November 8, 2018 Guardian Angel team to inquire on daily morning rounds if residents received food upon request, and will report findings to the Administrator in morning meeting.

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F 550	Continued From page 7 An interview with the Director of Nursing on 10/9/18 at 6:30 pm revealed the process for passing meal trays is to pass them as quickly as possible to keep the temperature at the desired temperature. She stated the staff then assisted residents that required assistance. She stated her expectation was residents would be assisted if they called out that they are hungry and would not be required to wait until all other residents had been served their meals.	F 550	Guardian Angel audit tool to be maintained by facility Administrator with report to QAPI. Process- All trays to be distributed for independent residents by staff first, with dependent trays served last as staff are available to assist. 4. The dining process audit tools by Risk Manager, dining room nurse, and Administrator will be summarized for 3 months to monthly QAPI with further monitoring to be decided by the QAPI committee if thresholds are not met.	
F 584 SS=C	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly,	F 584		11/8/18

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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 functional environment as evidenced by failure to maintain intact bed stations for the resident call light system, intact lens covers for over the bed lights, and maintain a removable filter in a Packaged Terminal Air Conditioner (PTAC) unit for one of four halls (100 Hall) reviewed for environment.

Findings included:

1. Observations conducted during a round on 10/7/18, which started at 10:17 AM, revealed the faceplate either missing or insecurely mounted for the resident call light system bed station in the following rooms: 102, 104, and 106.

An observation conducted of room 105 on 10/7/18 at 4:03 PM revealed the faceplate cover

F 584

This plan of correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that deficiencies exist or that one was cited correctly. The plan of correction is submitted to meet requirements established by federal and state law.

F 584 Safe/Clean/Comfortable/Homelike Environment
1.New faceplates ordered for rooms 102, 104, 105 and 106. Lens covers for bed lights were immediately replaced for rooms 104, 105, 106 and 107.
Removable air filter for Packaged Terminal Air Conditioner (PTAC) unit immediately replaced.

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F 584	Continued From page 9 missing from the resident call light system bed station and a wooden dowel in place to turn the call light reset button. Observations conducted during a round on 10/10/18, which started at 11:35 AM, revealed the faceplate either missing or insecurely mounted for the resident call light system bed station in the following rooms: 102, 104, and 106. An observation of room 105 revealed the faceplate cover missing from the resident call light system bed station and a wooden dowel in place for the call light reset button. An interview was conducted with Housekeeper (HSK) #1 on 10/10/18 at 11:37 AM. The HSK stated she did not write work orders. The HSK stated there was a log book at the nurses' station. The HSK stated if there was something of concern such as the air conditioner unit leaking, she would put that in the log book or tell maintenance personally. An interview was conducted with Charge Nurse (CN) #1 on 10/10/18 at 11:57 AM. The CN stated each unit had a communication book and that was how they communicated with the Maintenance Department or if they saw someone from the Maintenance Department they would tell them directly. Observations were conducted in conjunction with a round and interview with the Maintenance Assistant (MA) on 10/10/18 at 2:33 PM. Rooms 102, 104, 105, and 106 were observed to have the faceplate cover missing or insecurely mounted to the call light system bed station and in room 105 a wooden dowel had been installed in place of the original reset button mechanism.	F 584	2.100% room audit conducted by the Administrator (NHA) on November 5, 2018 to evaluate the condition of call light faceplates, lens covers for bed lights and removable air filters for PTAC units. All broken lens covers were repaired upon audit date. 19 faceplace covers were identified as needing repair and repairs began upon equipment delivery on November 8, 2018. Additional removable air filters for PTAC units were received on November 8, 2018 PTAC units identified as needing new filters will be corrected immediately by the Maintenance Department. 3.Education will be completed by Assistant Director of Nursing (ADON) to facility personnel on usage of maintenance book for identified repair needs beginning November 8, 2018. ADON will incorporate education for Maintenance protocols into New Hire Orientation beginning November 8, 2018. Administrator (NHA) will be responsible for Plan of Correction completion. 4.Maintenance Director will complete report of repairs and report to QAPI monthly on audit findings.	

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The MA stated the manufacturer of the call light system was no longer in business and he was unable to get parts for the call light system. The MA stated he was going to research options to address and repair the reset buttons and face plate covers for the call light system bed station.

Observations were conducted in conjunction with a round and interview with the Administrator on 10/10/18 at 3:41 PM. Rooms 102, 104, 105, and 106 were observed to have the faceplate cover missing or insecurely mounted and in room 105 a wooden dowel had been installed in place of the original reset button mechanism. The Administrator stated it was his expectation for the call light system bed stations to have an intact securely mounted faceplate cover and an appropriate mechanism for the reset button. In addition, the Administrator stated in the event a call light bed station was found to be in disrepair, it was his expectation for the staff person who discovered the issue to report the concern to the maintenance department.

2. Observations conducted during a round on 10/7/18, which started at 10:17 AM, revealed a cracked or broken lens cover on the over the bed light in the following rooms: 104, 105, 106, and 107.

Observations conducted during a round on 10/10/18, which started at 11:35 AM, revealed a cracked or broken lens cover on the over the bed light in the following rooms: 104, 105, 106, and 107.

An interview was conducted with Housekeeper (HSK) #1 on 10/10/18 at 11:37 AM. The HSK stated she did not write work orders. The HSK

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stated there was a log book at the nurses' station. The HSK stated if there was something of concern such as the air conditioner unit leaking, she would put that in the log book or tell maintenance personally.

An interview was conducted with Charge Nurse (CN) #1 on 10/10/18 at 11:57 AM. The CN stated each unit had a communication book and that was how they communicated with the Maintenance Department or if they saw someone from the Maintenance Department they would tell them directly.

Observations were conducted in conjunction with a round and interview with the Maintenance Assistant (MA) on 10/10/18 at 2:33 PM. Rooms 104, 105, 106, and 107 were observed to have had a cracked or broken lens cover on the over the bed light in the following rooms: 104, 105, 106, and 107. The MA stated he would replace the broken lens covers and he had lens covers on site to use as replacements.

Observations were conducted in conjunction with a round and interview with the Administrator on 10/10/18 at 3:41 PM. The MA had started to replace the cracked or broken lens covers on the over the bed lights. An observation of remaining cracked lens covers on the over the bed lights was made with the administrator during the round. The Administrator stated it was his expectation for over the bed lights to have an intact lens cover on the over the bed lights in the resident rooms. In addition, the Administrator stated in the event an over the bed light was found to be in disrepair, it was his expectation for the staff person who discovered the issue to report the concern to the maintenance

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FIVE OAKS MANOR	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

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F 584	Continued From page 12	F 584		

department.

3. An observation conducted on 10/7/18 at 4:03 revealed there was no removable filter in the Packaged Terminal Air Conditioner (PTAC) unit.

An observation conducted on 10/10/18 at 11:35 AM revealed there was no removable filter in the Packaged Terminal Air Conditioner (PTAC) unit.

An interview was conducted with Housekeeper (HSK) #1 on 10/10/18 at 11:37 AM. The HSK stated she did not write work orders. The HSK stated there was a log book at the nurses' station. The HSK stated if there was something of concern such as the air conditioner unit leaking, she would put that in the log book or tell maintenance personally.

An interview was conducted with Charge Nurse (CN) #1 on 10/10/18 at 11:57 AM. The CN stated each unit had a communication book and that was how they communicated with the Maintenance Department or if they saw someone from the Maintenance Department they would tell them directly.

Observations were conducted in conjunction with a round and interview with the Maintenance Assistant (MA) on 10/10/18 at 2:33 PM revealed there was no removable filter in the Packaged Terminal Air Conditioner (PTAC) unit. The MA stated the PTAC unit should have had a removable filter.

Observations were conducted in conjunction with a round and interview with the Administrator on 10/10/18 at 3:41 PM. The observation revealed the MA had installed a removable filter in the

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F 584	Continued From page 13 PTAC unit. The Administrator stated it was his expectation that if a PTAC unit was designed to have a removable filter, then a removable filter needed to be in place in the PTAC unit. In addition, the Administrator stated in the event a PTAC unit was found to be missing a removable filter, it was his expectation for the staff person who discovered the issue to report the concern to the maintenance department.	F 584		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews, the facility failed to complete a comprehensive significant change assessment on a resident after an amputation for 1 of 3 residents reviewed for Activities of Daily Living (Resident #56). Findings included: Resident #56 was originally admitted to the facility on 12/5/11 and was most recently admitted on	F 637	This plan of correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that deficiencies exist or that one was cited correctly. The plan of correction is submitted to meet requirements established by federal and state law. F 637: Comprehensive Assessment After	11/8/18

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F 637	Continued From page 14 5/11/18. The resident's cumulative diagnoses included: Hemiplegia (weakness on one side of the body), above the knee amputation of the left leg, difficulty swallowing, kidney disease, and generalized weakness. Review of Resident #56's Minimum Data Set (MDS) assessments revealed a comprehensive annual assessment with an Assessment Reference Date of 3/6/18. Review of the annual assessment revealed the resident had moderate cognitive impairment. The resident required extensive assistance of one person for bed mobility, transfer (such as from a bed to a wheelchair), locomotion on and off the unit. He was totally dependent on one person for toilet use, personal hygiene, and bathing. The resident required supervision of one person for eating. The resident was not coded as having had weight loss or weight gain. A review of the Resident #56's medical record revealed the resident was discharged from the facility and was hospitalized on 5/8/18. The resident was readmitted to the facility on 5/11/18 after having had an above the knee amputation of the left leg. Review of Resident #56's Physicians' orders revealed the resident had an order dated 5/12/18 for surgical wound care. Further review revealed the resident had an order dated 5/28/18 for speech therapy to evaluate and treat as indicated. Review of Resident #56's Minimum Data Set (MDS) assessments revealed a quarterly assessment with an Assessment Reference Date of 6/8/18. Review of the quarterly assessment revealed the resident had moderate cognitive	F 637	Significant Change 1) Resident #56 significant change in status assessment (SCSA) was completed and accepted in national repository capturing. 2) A review of current residents with prior Omnibus Budget Reconciliation Act (OBRA) assessment completed and an acute care admission in the last quarter reviewed for Significant Change by a certified resident assessment coordinator, with 3 additional Significant Change Minimum Data Set (MDS) assessment completed. 3) Education provided to Minimum Data Set (MDS) Team a certified resident assessment coordinator related to the RAI Guidelines for SCSA requirement when a resident□s condition changes from his/her baseline has occurred as indicated by comparison of the resident□s current status to the most recent comprehensive assessment and any subsequent Quarterly assessments. New hires responsible for scheduling and setting assessment reference dates will be trained by a certified resident assessment coordinator during orientation. Interdisciplinary team will review resident with a readmission or change in status for a significant change for either major improvement or decline during the standard clinical meeting, decision to proceed with SCSA or not will be determined up to 14 days and SCSA completed within 14 days after decision of SCSA. The MDS Coordinator or License nurse will complete a weekly audit of resident□s with observation of SCSA and	

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F 637	Continued From page 15 impairment. The resident required extensive assistance of one person for bed mobility, transfer (such as from a bed to a wheelchair) and eating. The resident was totally dependent on one person for locomotion on and off the unit, dressing, toilet use, personal hygiene, and bathing. The resident was not on a physician prescribed weight loss program and had had a weight loss of 5% or more in the last month or had lost 10% or more in the past 6 months. The resident was receiving Speech-Language Pathology and Audiology Services for 5 days during the assessment period for a total treatment time of 175 minutes. Review of Resident #56's most recent Minimum Data Set (MDS) assessment revealed a quarterly assessment with an Assessment Reference Date of 8/10/18. Review of the quarterly assessment revealed the resident had severe cognitive impairment. The resident was totally dependent on one person for bed mobility, transfer (such as from a bed to a wheelchair), locomotion on and off of the unit, dressing, toilet use, personal hygiene, and bathing. The resident required limited assistance of one person for eating. The resident was not on a physician prescribed weight loss program and had had a weight loss of 5% or more in the last month or had lost 10% or more in the past 6 months. The resident was coded as having had received Speech-Language Pathology and Audiology Services for 5 days during the assessment period for a total treatment time of 325 minutes. An interview as conducted with MDS Nurse #1 on 10/11/18 at 11:39 AM. The nurse stated Resident #56 was readmitted to the facility on 5/11/18 after having been hospitalized for having had an	F 637	SCSA scheduled no less than 3 months. 4) The Minimum Data Set (MDS) Coordinator will present the findings of the audit to the Quality Assurance Performance Improvement committee monthly for their review and recommendation if deemed necessary. The findings will be reported to the committee until the committee is satisfied sustainable compliance has been achieved.	

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amputation. The MDS Nurse stated she did not believe the resident had a significant change after his amputation.

An interview was conducted with Nursing Assistant (NA) #2 on 10/11/18 at 12:20 PM. The NA stated he had worked with Resident #56 both before and after he had the amputation. The NA stated the resident used to transfer with the assistance of one person before the amputation, but since the resident had had the amputation it took two people to transfer the resident.

An interview was conducted with Nurse #3 on 10/11/18 at 12:23 PM. The nurse stated Resident #56 had had some changes since he had the amputation. The nurse stated the resident had a family member pass away at about the same time as he had his leg amputated and the resident had experienced some depression. The nurse stated the resident had an incision on his stump which the nursing staff were providing dressings for. The nurse further stated the resident was participating in therapy after he had returned from having been hospitalized for the amputation.

A second interview was conducted with MDS Nurse #1 on 10/11/18 at 12:29 PM. The nurse stated she had looked at Resident #56 from a clinical standpoint and she did not believe he had a significant change after his amputation. The nurse stated when she had compared his 5-day Medicare assessment with an ARD of 5/18/18 with his other assessments, she did not see a significant change between those assessments. The nurse did state there were changes regarding the Activity of Daily Living (ADL) such as transfer and eating from the annual assessment and the assessment completed in

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F 637	Continued From page 17 May. The nurse stated assessing the resident and knowing his status prior to hospitalization, the resident did not seem like he had had a lot of changes. An interview was conducted with the Administrator and the Director of Nursing (DON) on 10/11/18 at 12:47 PM. The DON stated the resident could have been having a significant change but due to his hospitalization and subsequent recovery she felt it was it was more of an acute variance on the resident's condition rather than a significant change. The Administrator concurred with the DON in stating it could have been an acute variance or a significant change of condition. The DON stated the resident had required some more assistance when he had returned from the hospital as he adjusted to his amputation but had also become more dependent prior to his hospitalization and amputation. The DON further stated the resident's overall condition had improved since he had the amputation and was participating in more out of the room activities.	F 637		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer,	F 640		11/8/18

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F 640	Continued From page 18 reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the	F 640	This plan of correction constitutes the	

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facility failed to complete and transmit a discharge assessment for 1 of 1 resident reviewed for Resident Assessment (Resident #1).

The findings included:

Resident #1 was admitted to the facility on 5/22/18 and discharged on 6/11/18.

A review of Resident #1's transmitted Minimum Data Set (MDS) assessments revealed an Entry Tracking assessment dated 5/22/18 and an Admission Comprehensive assessment with an Assessment Reference Date (ARD) 5/29/18. The review revealed no transmittal or record of a discharge MDS for Resident #1.

Review of Resident #1's face sheet revealed the resident was discharged to home on 6/11/18 at 12:30 PM. Further review of the face sheet revealed his discharge status was documented as return not anticipated.

Review of Resident #1's nurses' notes revealed an entry documenting the resident was discharged to home on 6/11/18.

An interview was conducted MDS Nurse #1 on 10/9/18 at 10:39 AM. The MDS nurse stated she did not see a discharge assessment documented. The MDS nurse stated Resident #1 had been discharged from the facility on 6/11/18.

A second interview was conducted with MDS Nurse on 10/9/18. The MDS nurse stated she had reviewed the transmittal reports for the MDS assessments and confirmed a discharge assessment had not been completed for Resident #1 nor had a discharge assessment been

F 640

facilities written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that deficiencies exist or that one was cited correctly. The plan of correction is submitted to meet requirements established by federal and state law.

F 640: Encoding/Transmitting Resident Assessments

1) Resident # 1 Minimum Data Set (MDS) was transmitted and accepted.
2) Review of MDS schedule and completed MDS assessments requiring encoding and/or transmittal. No records identified requiring encoding transmission greater than Resident Assessment Instrument (RAI) guidelines.
3) Education provided to MDS Team by the MDS consultant , a certified resident assessment coordinator by November 3, 2018 of the responsibility of scheduling and transmitting MDS per the RAI guidelines define in 483.20. New hires responsible for MDS scheduling and transmitting will be trained by a certified resident assessment coordinator during orientation. MDS schedule from electronic health record MDS due calendar will be provided by the MDS Coordinator to the Administrator weekly to verify encoding of assessment. MDS Coordinator will provide copy of validation record monthly for Administrator or Director of Nursing review for assessments with late transmittal messages warnings. The Administrator or License Nurse will complete a weekly audit of assessments

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F 640	Continued From page 20 transmitted to the MDS national data base. The MDS nurse stated Resident #1 should have had a discharge assessment completed and it should have been transmitted timely. A review was completed of the facility's MDS submission report revealed the MDS dated 6/11/18 for Resident #1 was transmitted and accepted on 10/9/18. The submission report message for the assessment read: "Assessment completed late: Z0500B (assessment completion date) is more than 14 days after A2300 (Assessment Reference Date (ARD))." During an interview conducted with the Administrator on 10/11/18 at 12:47 PM the Administrator stated that it was his expectation for MDS assessments to be completed and transmitted timely. The Administrator further stated it was his expectation for the Resident Assessment Instrument (RAI) manual to be followed.	F 640	encoded and transmitted within the RAI guidelines for no less than 3 months. 4) The Adminstrator will present the audit findings to the Quality Assurance Performance Improvement committee monthly for their review and recommendation if deemed necessary. The findings will be reported to the committee until the committee is satisfied sustainable compliance has been achieved by 0% of submitted late assessments noted for no less than 3 months.	
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 sections A 1500, A 1510 and A 1550 of the Minimum Data Set (MDS) to reflect the Level II Preadmission Screening and Resident Review (PASARR) determination for 1 of 2 residents reviewed as Level II PASARR residents (Resident # 392).	F 641	This plan of correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that deficiencies exist or that one was cited correctly. The plan of correction is submitted to meet requirements established by federal and	11/8/18

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F 641	Continued From page 21 The findings included: Resident # 392 was admitted to the facility on 08/06/2018 with diagnoses that included symbolic dysfunctions, depression and traumatic subdural hematoma. A review of the medical record face sheet for Resident # 392 revealed that Resident # 392 was admitted with a Level II PASARR that expired on 12/12/2018. A review of the admission MDS for Resident # 392 dated 08/13/2018 revealed that section A 1500 was not coded as having a Level II PASARR. On 10/10/2018 at 8:10 AM an interview was conducted with the facility Marketing Director revealed that Resident # 392 was admitted with a Level II PASARR and that the Marketing Director had completed an admission communication form that revealed that Resident # 392 did have a Level II PASARR on admission to the facility and that all department managers (that included both MDS coordinators) had received the communication form. The Marketing Director explained that she completed the admission communication form for all newly admitted and readmitted residents and circled yes or no on the form to indicate PASARR Level of each resident. The Marketing Director revealed that when the face sheet of the resident was printed for the resident that PASARR Level II status was recorded at the bottom of the face sheet as well as the expiration date if there was one. The Marketing Director revealed that she was also responsible for submitting and updating PASARR Level II status of each resident as needed per the	F 641	state law. F 641: Accuracy of Assessments 1) Resident # 392 Minimum Data Set (MDS) was modified/corrected to accurately reflect Level II Pre-Admission Screen Resident Review (PASARR). 2) Review of current residents with Level II PASARR MDS reviewed for accuracy of coding. Modifications will be completed for any resident that may be identified as needing one. 3) Education provided to MDS Team by the regional MDS consultant by November 3, 2018 with responsibility of completing the assessment with information that accurately reflects the resident including accurately coding of Level II PASARR by reviewing supportive documentation in the medical record. New hires responsible for coding the MDS including PASARR will be trained by an MDS consultant during orientation. New process to place Level II PASARR in the resident s medical record and review during clinical meeting of new admission with Level II PASRR. MDS coordinator will provide monthly report generated from completed MDS to the Administrator, Social Worker and Admission Director of historical MDS answers of resident s coded with Level II coded in A 1500 on the last comprehensive assessment, a monthly MDS assessment calendar and the log of residents with Level II PASRR for verification of accuracy of coding. Social Worker or Admission Director will audit the MDS section A 1500 for accuracy of Level II coded weekly and the MDS	

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F 641	Continued From page 22 Department of Health and Human Services on the face sheet and on the 24-hour census report. The Marketing Director revealed that every weekday morning during a daily census meeting new admissions were reviewed and the PASARR status was also reviewed with all the department managers present in the meeting. A review of the admission communication form for Resident # 392 identified that Resident # 392 did have a Level II PASARR on admission. An interview conducted with MDS coordinator # 2 on 10/10/2018 at 9:01 AM revealed that the MDS coordinator had attended the morning census meeting that revealed that Resident # 392 was admitted with a Level II PASARR. MDS coordinator # 2 revealed that the PASARR Level II that had not been coded on the admission MDS for Resident # 392 as it was an over site of the coding on her behalf. On 10/11/2018 at 11:11 AM an interview conducted with the facility administrator revealed that the expectation was that the MDS coordinators code Level II PASARR status correctly on all comprehensive MDSs.	F 641	consultant will utilize a new MDS accuracy review tool to audit MDS for accuracy monthly for no less than 3 months. 4) The MDS Coordinator will present the audit findings to the Quality Assurance Performance Improvement committee monthly for their review and recommendation if deemed necessary. The findings will be reported to the committee until the committee is satisfied with 100% of accurate coding of Level II PASRR compliance has been achieved for no less than 3 months.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition	F 686		11/8/18

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

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demonstrates that they were unavoidable; and
(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
Based on record review, observations, and staff interviews, the facility failed to use a rolled washcloth to prevent skin breakdown in a resident ' s contracted right hand for 1 of 3 residents reviewed for skin integrity (Resident #121).

Findings included:

Resident #121 was admitted to the facility on 9/11/2018 with diagnoses to include lack of coordination, weakness, and hemiplegia after cerebral vascular accident. The admission Minimum Data Set (MDS) assessment dated 9/18/2018 assessed the resident to be moderately cognitively impaired with no behaviors or rejection of care. The resident required total assistance with bed mobility, transfers, dressing, eating, toileting and bathing. The MDS assessed him to have limited ROM of both left and right sides, and both upper and lower extremities.

The medical record was reviewed, and physician order dated 9/20/2018 was noted ordering a rolled washcloth to the right hand for optimal skin integrity, and the washcloth was to be removed for skin checks and hygiene.

The care plans for Resident #121 were reviewed and a care plan was in place dated 9/22/2018 related to impaired skin integrity of the right hand,

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F686 Increase/Prevent decrease ROM / Mobility

1. Resident #121's washcloth to right hand was immediately applied when informed by the Surveyor. A therapy referral was completed for Occupational Therapy to screen right hand contracture of resident #121 on October 11th, 2018.

2. Therapy to screen all residents with contracture splints/devices identified at risk for pressure ulcers as identified by Minimum Data Set (MDS) beginning November 6th, 2018. Care plans and restorative programs, reviewed/revised as needed by MDS Coordinator.

3. Therapy staff and assistants, restorative nurse, and restorative staff were educated by the Director of Nursing (DON) by November 8th, 2018 for

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with interventions to include a rolled washcloth in the right hand for skin integrity. A handwritten notation dated 10/8/2018 revealed Resident #121 was not compliant with keeping washcloths in the right hand.

The Maintenance Care Plan and Communication Tool (Kardex) was reviewed. The date of admission, 9/11/2018 was on the Kardex. Included in the "additional information" section was the intervention "rolled washcloth in right hand, remove for hygiene and daily skin checks".

Resident #121 was observed on 10/7/2018 at 3:19 PM. He did not have a rolled washcloth in his right hand. The right hand was noted to be severely contracted.

Resident #121 was observed on 10/8/2018 at 10:18 AM. He did not have a rolled washcloth in his right hand, but a small piece of gauze was noted under his right thumb. No wounds were noted on the right hand.

An observation of Resident #121 occurred on 10/9/2018 at 8:48 AM. He did not have a rolled washcloth in his right hand. Resident #121 was observed again at 12:58 PM and he did not have a rolled washcloth in his right hand.

Nursing assistant (NA) #2was interviewed on 10/9/2018 at 8:48 AM. NA #1 reported she did not know that Resident #121 should have a washcloth in his right hand to prevent skin breakdown. NA #2 further reported Resident #121 ' s skin was intact on the right hand.

NA #3 was interviewed on 10/9/2018 at 9:08 AM. She revealed she had been assigned to Resident

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residents transferring from active therapy caseload to restorative nursing, and those transferring from restorative nursing program to licensed nursing staff and certified nursing assistants. Splints or other devices will be demonstrated by the therapist prior to any written orders for the new device that will go to the restorative nursing program or licensed nursing staff and certified nursing assistants.

4. Effective week of November 5th, 2018 restorative nurse will audit splints, rolls for contracture management and accuracy, 3 times per week for 30 days and bring audit results to Quality Assurance Performance Improvement (QAPI) monthly for 3 months with further monitoring to be decided by the QAPI committee if thresholds are not met.

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#121 frequently but did not know Resident #121 should have a washcloth in his right hand. She reported Resident #121 ' s skin was intact on his right hand.
NA #4 was interviewed on 10/9/2018 at 9:49 AM. She reported she had provided care for Resident #121 in the past and he was supposed to have a splint or washcloth in his right hand.

Nurse #2 was interviewed on 10/9/2018 at 3:44 PM. Nurse #2 revealed that he had been assigned to Resident #121 and that he believed that physical therapy or the restorative aide was responsible for applying the washcloth to Resident #121 ' s right hand.
An interview was conducted with the Unit Manager #2 on 10/9/2018 at 5:03 PM. Unit Manager #2 reported the Resident #121 had a splint ordered, but he was unable to tolerate the splint and a washcloth was ordered to prevent skin breakdown in the contracted right hand. The Unit Manager went on to explain this was a nursing responsibility and the NA should be completing this task. Unit Manager went on to point out the directives on the Kardex for the washcloth to be applied to the right hand of Resident #121.
Restorative Aide (RA) #1 was interviewed on 10/10/2018 at 2:54 PM. RA #1 reported he received orders for all residents who were to participate in the Restorative program and he had orders for Resident #121 to provide him with passive range of motion for his upper and lower body, but he had not received orders to apply a splint or a washcloth to Resident #121 ' s right hand.

An Occupational Therapist (OT) #1 was interviewed on 10/11/2018 at 8:57 AM. She

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reported she received the order for the washcloth for Resident #121 and transcribed the order. She did not know the process for the order being transcribed to the Kardex but reported that the responsibility to apply the washcloth was nursing. OT #1 went on to explain that Resident #121 was unable to tolerate a splint in the tight contracture, so she had received an order for the washcloth to prevent skin breakdown. Resident #121 was to have the washcloth in place all the time and removed only for washing his skin and checking for skin breakdown. OT #1 concluded by reporting if she had intended the RA to apply the washcloth, she would have written directives for him, given the RA specific instructions and trained the RA in applying the washcloth and she had not done that.

The Director of Nursing (DON) was interviewed on 10/11/2018 at 12:18 PM. The DON reported it was her expectation that physician orders were followed by staff and that disciplines were clearly identified as responsible in the order.

The Administrator was interviewed on 10/11/2018 at 12:26 PM and he reported it was his expectation that staff follow the orders written by the physician and follow the directives on the Kardex.

F 693 SS=D Tube Feeding Mgmt/Restore Eating Skills
CFR(s): 483.25(g)(4)(5) — F 693 — 11/8/18

§483.25(g)(4)-(5) Enteral Nutrition
(Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must

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ensure that a resident-

§483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and

§483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interviews, the facility failed to store the piston and the syringe, separated, for one of one resident reviewed for tube feeding (Resident #56).

Findings included:

Resident #56 was originally admitted to the facility on 12/5/11 and was most recently admitted on 5/11/18. The resident's cumulative diagnoses included: Hemiplegia (weakness on one side of the body), difficulty swallowing, and generalized weakness.

Review of Resident #56's most recent Minimum Data Set (MDS) assessment revealed a quarterly assessment with an Assessment Reference Date of 8/10/18. Review of the quarterly assessment revealed the resident had severe cognitive impairment. The resident was totally dependent on one person for bed mobility, transfer (such as

F 693

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F 693 Tube Feeding Management
1. The nurse caring for resident #56 was educated on October 11th, 2018 by the Director of Nursing (DON) to the facility policy and procedure for Gastrospomy Tube (GT) syringe care, and competency was completed successfully.

2. No other residents were affected by the practice

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from a bed to a wheelchair), locomotion on and off of the unit, dressing, toilet use, personal hygiene, and bathing. The resident required limited assistance of one person for eating. The resident was not on a physician prescribed weight loss program and had had a weight loss of 5% or more in the last month or had lost 10% or more in the past 6 months. The resident was not coded as having had received a significant amount of hydration or nutrition via a feeding tube. The resident was coded as having had received Speech-Language Pathology and Audiology Services for 5 days during the assessment period for a total treatment time of 325 minutes.

An observation and interview were conducted of 10/11/18 at 9:01 AM. Resident #56 was unable to finish his nutritional supplement and Nurse #3 was observed preparing to administer the remaining nutritional supplement to the resident via his feeding tube as ordered. Nurse #3 was observed removing a clear plastic bag, containing a 2-ounce syringe and piston, from the medication cart. The nurse was then observed removing a 2-ounce syringe with the piston fully depressed within the syringe from the storage bag. Visible droplets of moisture were observed in the tip of the syringe. Prior to administration of the supplement, Nurse #3 stated the piston was stored inside of the syringe, in a depressed position, inside the storage bag, which was then stored in the medication cart. The nurse then proceeded to administer the supplement to the resident utilizing the syringe he had removed from the medication cart. Upon completion of the resident receiving the supplement via the feeding tube and the syringe, the nurse placed the plunger inside the syringe, depressed the plunger fully in the syringe, placed the syringe and

F 693

3. In-service completed by Assistant Director of Nursing (ADON) for current licensed nursing staff, Unit Coordinators, and nursing supervisors regarding GT syringe care policy and procedure. ADON completed GT syringe competencies for licensed nursing staff, Unit Coordinators, and nursing supervisors. ADON will include GT syringe care and competencies in new hire orientation for licensed nursing staff effective October 24th, 2018.

4. Risk manager (RM) to audit GT syringe care three times per week on alternating residents, beginning week of November 5th, 2018 for 30 days. Audit results to be reported to Director of Nursing (DON) at Quality Assurance Performance Improvement (QAPI) monthly by RM for 3 months, with further monitoring to be decided by the QAPI committee if thresholds are not met.

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F 693	Continued From page 29 plunger inside the clear plastic storage bag. There were droplets of moisture visible in the tip of the syringe. An interview was conducted with the Director of Nursing (DON) on 10/11/18 at 10:24 AM. The DON stated it was her expectation for the piston and the syringe to be stored separately in the bag.	F 693		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse	F 732		11/8/18

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F 732	Continued From page 30 staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to post current census and nursing staff data reviewed for posted staffing dated 10/07/2018 through 10/10/2018. Findings included: On 10/07/2018 at 9: 41 AM the posted staffing revealed the facility census was 138 on 10/07/2018. All 3 shifts for that date were completed with licensed nurse and nursing assistants (NAs) and the scheduled hours for the day for licensed nurses and NAs. On 10/08/2018 at 8: 52 AM the posted staffing revealed the facility census was 140 on 10/08/2018. All 3 shifts for that date were completed with licensed nurse and NAs scheduled to work the entire day along with their scheduled hours. On 10/09/2018 at 12: 25 PM the posted staffing revealed the facility census for the day was 138. All 3 shifts for that date were completed to reveal the number of licensed nurses and NAs and the hours each were expected to work that date.	F 732	This plan of correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that deficiencies exist or that one was cited correctly. The plan of correction is submitted to meet requirements established by federal and state law. F 732 Posted Nurse Staffing Information 1. No residents were named in the citation 2. Nurse staff and census posting form revised by Director of Nursing (DON) on October 11th, 2018 to provide facility name, current date, total number of hours worked by Registered Nurses (RN), Licensed Practical Nurses (LPN), Certified Nursing Assistants (CNA), and current resident census by shift. 3. New daily staff census form Education was completed by the DON on October 19th, 2018 with the scheduler, licensed nursing staff, and nurse supervisors on	

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F 732	Continued From page 31 On 10/10/2018 at 9: 37 AM the posted staffing revealed the facility census that date was 141. All 3 shifts for that date were completed to reveal the number of licensed nurses and NAs scheduled to work that date and the hours to be worked. On 10/10/2018 at 9: 55 AM an interview conducted with the facility nurse staff scheduler revealed that she completed and posted the daily staffing forms every week day and completed the posted staffing form for the weekends to be posted by the manager on duty (MOD). The staff scheduler revealed that she received the midnight census number from the business office manager (BOM) in an e mail every morning and that was the number she used to post on the daily staffing sheet. The staff scheduler revealed that she completed the posted nurse staff form every weekday morning based on the master nurse staff schedule and it was posted for all 3 shifts for the entire day. The staff scheduler revealed that sometimes she updated the posted schedule form before she left on the evening (3:00PM - 11:00PM) shift or a licensed nurse may change it, but that most days the original posted staffing form remained as it was posted in the morning even if the census number or staffing numbers changed during the 24 hour time period. The staff scheduler revealed that she would make changes to the posted staff form the next morning if needed to reflect any changes that had been made to the census or nurse staff schedule on the previous date. An interview conducted with the Director of Nurses (DON) on 10/10/2018 at 9: 55 AM revealed that the DON was not aware that the posted staff form be updated every shift to reflect the current status of the facility census and nurse	F 732	the regulations regarding nurse staff posting, and the adjustments to the census section as changes occur during each shift. Assistant Director of Nursing (ADON) to audit daily census posting three times weekly for 3 months and Weekend Nurse Supervisor to audit daily census posting on Saturday and Sunday to ensure solutions are sustained. 4. Assistant Director of Nursing (ADON) to report both weekday and weekend audits of daily census posting to Quality Assurance Performance Improvement (QAPI) Committee monthly for 3 months, with further monitoring to be decided by the QAPI committee on audit findings.	

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F 732	Continued From page 32 staff. The DON expected that the posted staffing form be completed accurately to reflect the current nurse staff and census present in the facility on any given date, time and shift and be updated during the day to reflect any changes.	F 732		
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide 1 of 1 resident (Resident # 32) with adaptive equipment for dining. The findings included: Resident # 32 was admitted to the facility on 07/13/2016 with diagnoses that included adult failure to thrive, dysphagia, lack of coordination, dementia and muscle weakness. A quarterly Minimum Data Set (MDS) dated 07/24/2018 revealed that Resident # 32 was severely cognitively impaired, required set up assist with meals, received a mechanically altered diet and had no weight loss or weight gain. A review of a care plan initiated on 02/21/2018 and updated as needed and at least quarterly revealed that Resident # 32 had poor oral (po)	F 810	This plan of correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that deficiencies exist or that one was cited correctly. The plan of correction is submitted to meet requirements established by federal and state law. F 810 Assistive Devices Eating Equipment/Utensils 1. Resident #32 was provided 2 handled cup with lid 2. All residents with adaptive equipment were audited for compliance by the Certified Dietary Manager(CDM) on October 9, 2018 3. Kitchen staff were in-serviced by Registered Dietician (RD) regarding the policy for adaptive equipment and following the meal tray ticket for adaptive	11/8/18

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intake and a gradual weight loss and the goal that Resident # 32 would tolerate the diet through the next review. Interventions included to assist Resident # 32 with meals, provide a scoop plate and provide 2 handled cups with lids.

A review of a diet slip dated 08/15/2018 revealed that Resident # 32 was to be served all beverages in 2 handled cups.

A review of a physician (MD) order dated 08/17/2018 revealed that Resident # 32 was to have a water cup with 2 handles and a lid at the bedside.

An observation on 10/09/2018 at 8:36 AM revealed a styrofoam cup with a lid and a straw on the over bed table next to the bed of Resident # 32. The breakfast tray of Resident # 32 was delivered by a nurse assistant (NA) # 5 and contained two 2 handled cups turned upside down. NA # 5 lifted the cups and revealed that she would use the 2 handled cups for Resident # 32 if they had lids on them. NA # 5 revealed that she was not aware that Resident # 32 needed the 2-handled cup with a lid kept as the bedside at all times.

An interview with nurse # 3 on 10/09/2018 at 8:40 AM revealed that nurse # 3 was not aware if Resident # 32 was to have plastic cups with 2 handles and lids on his meal trays or at his bed side. Upon review of the Kardex for Resident # 32 with nurse # 3 revealed no documentation that Resident # 32 was to have 2 handled cups with lids at any time.

On 10/09/2018 at 9:00 AM an observation and interview was conducted with the Registered

F 810

equipment on the tray line on October 11,2018. Nurses, NA's, Restorative Aides, and Nurse Unit Coordinators began in-service training by Assistant Director of Nursing (ADON) on November 8, 2018. Care Plans and Kardexs updated by Minimum Data Set Coordinator (MDS)for assistive devices eating equipment/utensils beginning October 9, 2018 and continued as changes occur.

4. Risk Assessment Nurse to audit equipment during alternate meal times, 3 days per week for 30 days for compliance . Audit results to be reported to Quality Assurance Performance Improvement (QAPI) monthly by Risk Assessment Nurse with further monitoring to be decided by the QAPI committee if thresholds are not met.

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Dietician (RD) of Resident # 32. NA # 5 was assisting Resident # 32 with the meal. NA # 5 showed the RD the two 2 handled cups on the meal tray and the RD revealed that she was only employed for 2 weeks and was not aware of the need for Resident # 32 to have 2 handled cups with lids on the over bed table or on the meal tray and that she had been informed by the nurse staff that Resident # 32 has a decline in his eating ability and that the RD had made a referral to the Rehabilitation department related to the need for more assist for Resident # 32.

A review of the MD orders and care plan for Resident # 32 made with the RD on 10/09/2018 at 9: 16 AM revealed that on 08/17/2018 the MD ordered a 2 handled plastic cup with a lid with water to be maintained on the over bed table of Resident # 32 and that this had also been added to the care plan of Resident # 32 on 08/17/2018.

An interview conducted with OT (Occupational Therapist) # 2 on 10/09/2018 at 10:00 AM revealed that she had Resident # 32 on her caseload in August 2018 and had made a recommendation that Resident # 32 used 2 handled plastic cups with lids at the bedside and OT #2 revealed that she had received and wrote the MD order for the 2 handled plastic cups with lids on 08/17/2018. OT #2 revealed that Resident # 32 had declined more since August 2018 and required more assist with meals and that Resident # 32 had been placed back on the OT caseload.

On 10/10/2018 at 9:55 AM an interview conducted with the Director of Nurse (DON) revealed that the DON expected that MD orders be followed and that the MD orders be updated

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	345186	A. BUILDING ______ B. WING ______	C 10/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS MANOR	**413 WINECOFF SCHOOL ROAD CONCORD, NC 28027**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 810	Continued From page 35 on resident Kardex and care plans by all licensed nurses.	F 810		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to keep the kitchen ' s dry storage room floor, ice machine and the walk-in refrigerator clean, failed to ensure proper storage of food and nutritional supplements and failed to utilize a clean utensil to prepare resident food. Findings included: 1. Observations during an initial tour of the kitchen on 10/7/2018 from 9:43 AM to 10:00 AM revealed the following:	F 812	This plan of correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that deficiencies exist or that one was cited correctly. The plan of correction is submitted to meet requirements established by federal and state law. F 812 Store/Prepare/Serve Sanitation 1. Food residue immediately cleaned	11/8/18

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F 812 Continued From page 36

a. The dry storage room was noted to have multiple packets of artificial sweetener scattered across the floor.

b. There was rack of canned foods in the storage room and a dented can of spaghetti sauce was observed on the rack.

c. The inside compartment of the kitchen ' s ice machine was not clean with a black, mold-like substance that appeared wet.

d. The walk-in refrigerator was noted to have spilled red colored sticky substance on the right-hand wall that had dripped down the wall and puddled onto the floor of the refrigerator.

e. The walk-in refrigerator was noted to have 5 individual cartons of nutritional supplements on the floor.

Cook #1 was interviewed on 10/7/2018 at 9:43 AM during the initial tour. She reported the Dietary Manager (DM) was not working this date. She further reported the dented can had only a small dent and if the dent was larger, they would throw it out. Cook #1 further reported the ice machines were cleaned "every 3 months or so" but she was not certain the last time the ice machine had been cleaned. She went on to report she was not aware the red substance was on the wall and floor of the walk-in refrigerator.

The DM was interviewed on 10/10/2018 at 2:40 PM. She reported the interior of the ice machine was cleaned weekly, and the staff had been in-serviced on keeping the floors of the dry storage room and refrigerator clean, as well as

F 812

and sugar packets discarded
2. Policy and procedure for kitchen sanitation and cleaning schedules were reviewed by the Registered Dietician (RD) and Certified Dietary Manager (CDM) prior to November 8, 2018.
3. In-service was completed with kitchen staff by CDM on the policy and procedure and schedules reviewed for each shift and job duties assigned prior to November 8, 2018. Kitchen Sanitation and cleaning schedules added to new hire orientation process for dietary employees on November 8, 2018
4. RD to complete kitchen sanitation rounds weekly at undetermined times to observe sanitation compliance on different shifts for 4 weeks and report to Quality Aassurance Performance Improvement (QAPI) monthly with further monitoring to be decided by the QAPI committee if thresholds are not met.

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F 812	Continued From page 37	F 812		

cleaning up spills as they happen. The DM reported it was her expectation that the floors are kept clean and free from items that fell off the shelves, spills were wiped up immediately, equipment was cleaned as scheduled and as needed and dented cans were placed in her office for return.

The Administrator was interviewed on 10/11/2018 at 12:29 PM. He reported it was his expectation for kitchen staff to follow all sanitary procedures to prevent cross-contamination, to keep the kitchen floor free of debris, for the ice machine and kitchen equipment to be free of mold, for spills to be cleaned as they happened and for dented cans to be removed from rotation to prevent use.

2. The kitchen was observed again on 10/9/2018 from 12:00 PM until 1:11 PM. A Dietary Aide (DA) #2 was observed removing soiled gloves from his hands and obtaining a spoon from a kitchen shelf. He placed the spoon in his left chest pocket of his uniform while he washed his hands. DA #2 was observed applying clean gloves and/ then he removed the spoon from his left front chest pocket and used it to scoop out chicken salad and placed it on bread to prepare a sandwich for a resident.
DA #2 was stopped from his activity and interviewed on 10/9/2018 at 1:03 PM. He reported he was not certain why had had placed the spoon in his pocket.

The DM was interviewed on 10/10/2018 at 2:40 PM. The DM went on to explain that DA #2 was very nervous during the observation of the kitchen. The DM reported it was her expectation staff performed hand hygiene and obtained clean

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F 812	Continued From page 38 utensils for use to serve food. The Administrator was interviewed on 10/11/2018 at 12:29 PM. He reported it was his expectation for kitchen staff to follow all sanitary procedures to prevent cross-contamination.	F 812		
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and	F 838		11/8/18

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F 838	Continued From page 39 (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to conduct and document a facility-wide assessment to determine what resources were necessary to care for the resident population competently during day to day operations and emergencies. The findings included:	F 838	This plan of correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that deficiencies exist or that one was cited correctly. The plan of correction is submitted to meet requirements established by federal and	

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Review of the facility assessment revealed it did not contain the facility's resident population, the care required by the resident population, staff competencies, physical environment, and cultural, ethnic, and religious factors that may affect resident's care. It also did not contain the facility's resources such as services provided, personnel, and contracts with third parties, and managing resident records.

An interview was conducted with the Administrator on 10/10/18 at 10:28 AM. The Administrator stated the former Director of Nursing (DON) had been working on the facility assessment as one of her projects. The Administrator stated the former DON had resigned prior to her completing the facility assessment. The Administrator stated the facility assessment had been reviewed and updated in 2018 but the assessment was incomplete.

F 838

state law.

F 838 Facility Assessment
1.No residents were named in the citation
2.Facility Assessment to be updated completely by the Administrator (NHA) to include the following areas:
A. The facility's resident population
B. The care required by the resident population
C. Staff competencies
D. Physical environment, and cultural, ethnic, and religious factors that may affect resident's care.
E. The facility's resources including services provided, personnel, contracts with third parties, and managing resident records.

3.Facility Assessment will be reviewed and approved by Facility Safety Committee and reviewed annually with committee. Administrator will update changes to Facility Assessment as they change throughout the year.

4.Updated Facility Assessment will be presented by the NHA to Quality Assurance Performance Improvement (QAPI) Committee for review and any updates will be reviewed/approved by QAPI Committee as they arise.