STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345304	A. BUILDING _____ B. WING _____	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER NURSING CARE/SHAM	2727 SHAMROCK DRIVE CHARLOTTE, NC 28205

(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 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 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	F 550		1/3/19

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

Electronically Signed | 12/27/2018

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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F 550	Continued From page 1 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review the facility failed to maintain dignity for a resident with a urinary catheter, the urine collection bag was visible from the hallway for 1 of 3 residents with urinary catheters (Resident #47). The findings included: Resident #47 was admitted to the facility on 02/16/09 with diagnoses that included neuromuscular dysfunction of the bladder. The most recent Minimum Data Set (MDS) dated 11/25/18 specified the resident's cognition was intact and he had an indwelling urinary catheter. On 12/02/18 at 2:44 PM observations made of Resident #47 in his room revealed his urine catheter bag attached to the bed visible from the hallway. The urine bag was full of urine. On 12/02/18 at 4:30 PM a second observation was made of Resident #47 and his urine catheter bag remained visible from the hallway with urine in it. On 12/05/18 at 10:00 AM the Director of Nursing (DON) was interviewed and reported staff were trained to keep urinary catheters covered. She added that the urine bags should be placed in a blue privacy bag to prevent a resident's urine from being visible. On 12/05/18 at 1:00 PM Resident #47 was interviewed in his room about his urinary catheter.	F 550	Brian Center, Shamrock POC Deficiency Statement: Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. F550 Based on observations, resident and staff interviews and record review, the facility failed to maintain dignity for a resident with a urinary catheter; the urine collection bag was visible from the hallway for 1 of 3 residents with urinary catheters (Resident #47). Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; • Resident #47 identified during the survey, the urine collection catheter bag was secured in a privacy bag on 12/3/18. • The nurse and Nursing Assistant received a one-on-one in-service or will receive one prior to working a shift by DON or RN designee on securing urine collection bag in a privacy bag.	

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F 550	Continued From page 2 He explained that he knew the bag was at times visible from the hallway because staff were able to see when it needed to be emptied. The resident explained he had the urinary catheter so long that he didn't think anything about the sight of urine. He added that the bag should be covered because the sight of urine might make visitors uncomfortable.	F 550	• Completion by 01/3/19. Address how corrective action will be accomplished for those residents having a potential to be affected by the same deficient practice; • All residents with a urine collection bag were identified. An audit was completed by the DON and/or RN designee to determine if all urine collection bags were secured by a privacy bag to prevent urine from being visible. (Completion by 01/3/19). • All residents with a urine collection bag upon admission and/or change of condition will have a privacy bag secured to prevent urine from being visible. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur; • An in-service will be completed for all nursing staff (licensed and certified) by the Director of Nursing and/or RN designee regarding these practices to include securing urine collection bags in privacy bags. Any member of the nursing staff who is unable to attend the mandatory in-service by 1/3/19 will receive the in-service prior to working a shift. • Assistant Director of Nursing or RN designee will report any new urine collection bag in the morning clinical stand up meeting daily (Monday – Friday) and/or reported to the weekend Charge nurse. • Any issues identified will be corrected immediately and will also be taken to the daily clinical start-up meeting (Monday –	

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F 550	Continued From page 3	F 550	Friday) and/or reported to the weekend Charge nurse and QAPI (Completion 1/3/19) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The PoC is integrated into the quality assurance system of the facility. • Facility will change over to the Fig Leaf Lite Bag which has a built in covering for urine collection bags as of 1/3/19. Auditing and monitoring will remain in place as outlined, adhering to the timeframe and guidelines. • Director of Nursing and/or RN designee will audit 100% of residents with urine collection bags secured with privacy bag daily x 1 month, then weekly x 2 months to ensure compliance. Any issues identified will be corrected at that time. Results of the monitoring will be shared with the Administrator and/or Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a	F 623		1/3/19

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F 623	Continued From page 4	F 623		

resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

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F 623	Continued From page 5 §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon	F 623		

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F 623	Continued From page 6 as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, Emergency Department Social Worker, Ombudsman and staff interviews, the facility failed to provide a written notice of transfer/discharge for a facility initiated discharge to the hospital for 1 of 1 resident (Resident #317) and failed to notify the Ombudsman of hospital transfers for 5 of 7 residents (Resident #317, #316, #318, #48 and #25) reviewed for hospitalizations. Findings included: 1. Resident #317 admitted to the facility on 3/25/2018. Resident #317 had diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, and unspecified symptoms and signs involving cognitive functions following cerebral infarction. Review of quarterly Minimum Data Set (MDS) dated 6/25/18 revealed that resident was	F 623	F623 Based on record review, Emergency Department Social Worker, Ombudsman and staff interviews, the facility failed to provide a written notice of transfer/discharge for a facility initiated discharge to the hospital for 1 of 1 resident (Resident #317) and failed to notify the Ombudsman of hospital transfers for 5 of 7 residents (Resident #316, #317, #318, #48 and #25) reviewed for hospitalizations. • The plan for correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; Facility failed to notify resident #317 with a written notice of discharge for a facility initiated discharge. Facility failed to notify the Ombudsman of hospital transfers for residents #316, 317, #318, #48 and #25. • The procedure for implementing the acceptable plan of correction for the	

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F 623	Continued From page 7 cognitively intact. Resident required extensive assistance with bed mobility and transfers, toilet use and personal hygiene. Resident had impairment on one side and utilized a wheelchair for ambulation. No behavioral symptoms coded. Review of Resident #317's medical record revealed that he was discharged to the hospital on 6/25/2018 due to aggressive behaviors. No written notice of discharge was documented as being provided to the resident, the responsible party (RP) or the Ombudsman. A telephone interview was completed at 8:58 AM on 12/4/2018 with the Social Worker (SW) at the hospital Emergency Department (ED). The SW at the ED stated he remembered the case with Resident #317. Resident #317 was involuntarily committed to the ED for aggressive behaviors initiated by the facility. The SW at the ED stated Resident #317 was in the ED for several days for stabilization. The SW at the ED further explained he contacted the facility once Resident #317 was ready for discharge and the facility informed him that Resident #317 had been discharged from the facility due to aggressive behaviors and would not be allowed to return. The SW at the ED continued to explain he requested Resident #317's notice of transfer/ discharge and the facility was unable to produce required transfer/ discharge notice. The SW at the ED verbalized Resident #317 received assistance from ED staff with locating alternative placement. Resident #317 was discharged home with family and community resources.	F 623	specific deficiency cited; The Administrator that was identified during the survey as not notifying the resident with a 30 day written notice of discharge from the facility is no longer an employee as of 10/01/18. The Social Worker identified during the survey as not notifying the Ombudsman of transfer/discharge resigned as of 12/06/18. The Administrator is currently in the process of recruiting a new Social Services Manager and will have an offer extended by 1/11/19. A one on one in-service was received or will be completed prior to the next working shift by the Administrator for the Social Services Manager or Social Services Designee, to include notifying the resident and/or representative and to other officials in accordance with state law of a 30 day written notice of discharge initiated by the facility. A one on one in-service was received or will be completed prior to the next working shift by the Administrator for the Social Services Manager or Social Services Designee, to include notifying the Ombudsman of hospital transfers for hospitalization. Any issues identified will be corrected immediately and will also be taken to daily standup meetings (Monday – Friday) and/or reported to Administrator on weekends and QAPI. Completion 01/3/19 • The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains	

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F 623	Continued From page 8 An interview was completed on 12/4/2018 at 3:22 PM with the Assistant Director of Nursing (ADON). The ADON stated that Resident #317 was involuntarily committed to the hospital due to aggressive behaviors. The ADON explained that a transfer/discharge notice was not issued due to not wanting to further upset Resident #317. The ADON further stated that Resident #317 was not able to return to the facility due to aggressive behaviors. An interview was completed with the prior Administrator on 12/5/18 at 8:11 AM. The prior Administrator stated he recalled the incident regarding Resident #317. The prior Administrator verbalized Resident #317 had increasing behaviors and needed to be hospitalized. The prior Administrator explained he was in contact with the hospital and informed the hospital that Resident #317 would not be allowed to return to the facility. The prior Administrator further stated a notice of transfer/ discharge was not issued due to the urgency and severity of the situation. The prior Administrator stated he would expect for the facility Social Worker and the Administrator to work together to issue a notice of transfer/ discharge regardless of the situation as quickly as possible to the resident and/ or the responsible party (RP), and notify the Ombudsman. An interview was completed with the facility Social Worker (SW) on 12/5/2018 at 8:56 AM. The SW stated she was not certain if a notice of transfer/ discharge was completed for Resident #317. The SW further stated that she did not complete a notice of transfer/ discharge for Resident #317. The SW also verbalized she was	F 623	corrected and/or in compliance with the regulatory requirements; the title of the person responsible for implementing the acceptable plan of correction. Dates when corrective action will be completed. That corrective action dates must be acceptable to the State. • In-service education for 100% of all licensed nurses will be completed by DON and/or designee to complete the Nursing Home to Hospital Transfer assessment will be completed by 1/3/19. • Currently, the Administrator will audit 100% of 30 day written notices for discharges and transfer/hospital discharges to ensure resident and/or resident representative and Ombudsman are notified, and if the alleged violation is verified appropriate corrective action will be taken weekly x 3 months to ensure compliance. • Medical Records designee will also verify that medical records accurately reflect the discharges and transfer/hospital discharges weekly x 3 months to ensure compliance. Any identified issues will be corrected at that time and disciplinary action will be provided to the staff member. • Results of the monitoring will be shared with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. Completion 01/3/19	

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not aware of who would be responsible for making notification to the Ombudsman of transfers or discharges. The SW explained that she has not been informing the Ombudsman of any transfers or discharges. The SW confirmed that she did not notify Resident #317 or the Ombudsman in writing of the notice of transfer/ discharge.

An interview was completed with the current Administrator on 12/5/2018 at 3:08 PM. The current Administrator stated that his expectation would be for the Social Worker, in conjunction with the Administrator, to notify the resident and/ or the RP in writing of the notice of transfer/discharge and also notify the Ombudsman in writing regarding any transfer and/ or discharge.

A telephone interview was completed with the Ombudsman on 12/6/2018 at 8:55 AM. The Ombudsman stated that she has not received any notifications of transfers and/ or discharges from the facility.

2. Resident #316 was admitted to the facility on 8/14/2015. Resident had diagnoses that included hemiplegia, vascular dementia without behaviors, and dysphagia. Review of the quarterly Minimum Data Set (MDS) dated 9/5/2018 revealed that Resident #316 was severely cognitively impaired for decision making.

Review of Resident #316's medical record revealed she was transferred to the hospital on

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9/21/2018 due to critical lab values and decreased appetite. No written notice of transfer was documented as being provided to the resident, the RP or the Ombudsman.

An interview was completed with the facility Social Worker (SW) on 12/5/2018 at 8:56 AM. The SW verbalized she was not aware of who would be responsible for making notification to the Ombudsman of transfers or discharges. The SW explained that she has not been informing the Ombudsman of any transfers or discharges. The SW confirmed that she did not notify Resident #316's RP or the Ombudsman in writing of the notice of transfer/ discharge.

An interview was completed with the current Administrator on 12/5/2018 at 3:08 PM. The current Administrator stated that his expectation would be for the Social Worker, in conjunction with the Administrator, to notify the resident and/ or the RP in writing of the notice of transfer/ discharge and also notify the Ombudsman in writing regarding any transfer and/ or discharge.

A telephone interview was completed with the Ombudsman on 12/6/2018 at 8:55 AM. The Ombudsman stated that she has not received any notifications of transfers and/ or discharges from the facility.

3. Resident #318 was admitted to the facility on 8/7/2017. Resident #318 had diagnoses that included neuromuscular dysfunction of bladder and C5 through C7 complete. Review of the

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discharge Minimum Data Set (MDS) dated 6/27/2018 revealed that Resident #318 was cognitively intact.

Review of Resident #318's medical record revealed she was transferred to the hospital on 6/15/2018 due to shoulder and hip pain. No written notice of transfer was documented as being provided to the resident, the RP or the Ombudsman.

An interview was completed with the facility Social Worker (SW) on 12/5/2018 at 8:56 AM. The SW verbalized she was not aware of who would be responsible for making notification to the Ombudsman of transfers or discharges. The SW explained that she has not been informing the Ombudsman of any transfers or discharges. The SW confirmed that she did not notify Resident #318 or the Ombudsman in writing of the notice of transfer/ discharge.

An interview was completed with the current Administrator on 12/5/2018 at 3:08 PM. The current Administrator stated that his expectation would be for the Social Worker, in conjunction with the Administrator, to notify the resident and/ or the RP in writing of the notice of transfer/ discharge and also notify the Ombudsman in writing regarding any transfer and/ or discharge.

A telephone interview was completed with the Ombudsman on 12/6/2018 at 8:55 AM. The Ombudsman stated that she has not received any notifications of transfers and/ or discharges from

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F 623	Continued From page 12	F 623		

the facility.

4. Resident #48 was readmitted to the facility on 1/19/18. Resident #48's medical diagnoses were inclusive of unspecified joint contracture.

A review of the quarterly Minimum Data Set (MDS) dated 10/22/18 revealed Resident#48 was cognitively intact.

A review of Resident #48's medical record revealed he was transferred to the hospital on 2/19/18 and returned to the facility on 2/20/18. No written notice of transfer was documented as being provided to the resident or the Ombudsman.

An interview was completed with the Social Worker (SW) on 12/5/2018 at 8:56 AM. The SW stated she was not aware of who would be responsible for making notifications to the Ombudsman of transfers or discharges. The SW explained she had not informed the Ombudsman of any transfers or discharges. The SW confirmed she had not notified Resident #48 or the Ombudsman in writing of the notice of transfer/discharge.

An interview was completed with the current Administrator on 12/5/2018 at 3:08 PM. The current Administrator stated his expectation would be for the Social Worker, in conjunction with the Administrator, to notify the resident and/or the RP in writing of the notice of transfer/discharge and notify the Ombudsman in writing regarding any transfer and/or discharge.

A telephone interview was completed with the Ombudsman on 12/6/2018 at 8:55 AM. The

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Ombudsman stated she had not received any written notifications of transfers and/ or discharges from the facility.

5. Resident #25 was readmitted to the facility on 10/24/18. Resident#25's medical diagnoses were inclusive of type 2 diabetes mellitus and end stage renal disease.

Review of the quarterly Minimum Data Set (MDS) dated 10/9/18 revealed Resident #25 was cognitively intact.

Review of Resident #25's medical record revealed multiple discharges (12/13/18, 3/13/18, 4/27/18, 5/22/18, 6/18/18, 7/16/18, 8/10/18, 8/19/18, 9/17/18, 10/1/18, 10/6/18, and 10/11/18) from the facility with hospital admissions. No written notice of discharge was documented as being provided to the resident or the Ombudsman.

An interview was completed with the Social Worker (SW) on 12/5/2018 at 8:56 AM. The SW stated she was not aware of who would be responsible for making notification to the Ombudsman of transfers or discharges. The SW explained she had not been informed the Ombudsman of any transfers or discharges. The SW confirmed she had not notified Resident #25 or the Ombudsman in writing of the notice of transfer/discharge.

An interview was completed with the current Administrator on 12/5/2018 at 3:08 PM. The current Administrator stated his expectation would be for the Social Worker, in conjunction with the Administrator, to notify the resident and/or the RP in writing of the notice of transfer/discharge and

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F 623	Continued From page 14 notify the Ombudsman in writing regarding any transfer and/ or discharge. A telephone interview was completed with the Ombudsman on 12/6/2018 at 8:55 AM. The Ombudsman stated she had not received any written notifications of transfers and/ or discharges from the facility.	F 623		
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 interview the facility failed to code that a Hospice resident was terminally ill and receiving Hospice services while at the facility for 1 of 2 sampled residents receiving Hospice services (Resident #54). Findings included: Resident #54 was admitted to the facility on 6/6/2016. Diagnoses included Alzheimer's disease, epilepsy and cerebral infarction. A Hospice contract dated 2/3/2018 certified that Resident #54 was admitted under the care and services of Hospice for end of life. The quarterly Minimum Data Set (MDS) dated 11/2/2018 specified the resident's cognition was severely impaired. Review of Section J1400 (Prognosis-Does the resident have a condition or	F 641	F641 Based on record review and staff interview the facility failed to code that a Hospice resident was terminally ill and receiving Hospice services while at the facility for 1 of 2 sampled residents receiving Hospice services (Resident #54) • Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Facility failed to accurately code that a Hospice resident was terminally ill and receiving Hospice services, identified in MDS Section J1400 and MDS Section O. Resident #54 MDS was modified and coded accurately as receiving Hospice services on 12/4/18. The MDS nurse identified during the survey as not coding accurately resident #54 received one-on-one in-service education by the District Director Care	1/3/19

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F 641	Continued From page 15 chronic disease that may result in a life expectancy of less than 6 months?) was coded as Resident #54 not having less than 6 months to live. Review of Section O (Special Programs/ Treatments) was coded as Resident #54 not receiving Hospice services. On 12/4/2018 at 12:45 PM an interview was completed with the MDS Nurse. The MDS Nurse stated Section J1400 (Prognosis-Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months?) was coded No in error for Resident #54. The MDS Nurse stated any resident receiving hospice services should be coded Yes for Section J1400. On 12/4/2018 during the same interview with the MDS Nurse, she also stated Section O (Special Programs/ Treatments) - Hospice was coded No in error. The MDS Nurse verbalized Resident #54 currently received Hospice services and should have been coded Yes. The MDS Nurse further explained the assessment needed to be modified to reflect the correct prognosis and services being received by Resident #54. On 12/4/2018 at 5:07 PM an interview was completed with the Administrator. The Administrator stated he expected the MDS to be coded as accurately as possible to reflect the current status of the resident by the MDS Nurse.	F 641	Manager to include accurately coding a resident as receiving Hospice services per the RAI manual (Completed on 12/27/18) • Address how corrective action will be accomplished for those residents having a potential to be affected by the same deficient practice; All residents receiving Hospice services were identified. A 100% audit was completed by Director of Nursing and/or designee to determine whether the residents were coded accurately as receiving Hospice services per MD orders (12/4/18). MDS nurse will be re-educated by the District Director Care Manager to ensure residents receiving hospice services are coded accurately per the RAI manual. (Completion 12/27/18) • Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur; Residents receiving Hospice services will be reviewed weekly during “At Risk” meetings by the MDS nurse and IDT team, to ensure compliance with coding accurately per RAI manual. Any issues identified will be corrected immediately and will be also taken to morning Stand-up meeting and reported to QAPI. (Completion 1/3/19) • Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must	

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F 641	Continued From page 16	F 641	be implemented and the corrective action evaluated for its effectiveness. The PoC is integrated into the quality assurance system of the facility. The MDS Coordinator and/or designee will randomly audit five completed MDS's weekly for 12 weeks and then five random MDS's monthly for an additional 3 months to verify accurate coding of Sections J and O of the MDS. Results of the monitoring will be shared with Administrator and/or designee on a weekly basis and with QAPI monthly for a period at which time frequency will be determined by the QAPI committee.	
F 685 SS=E	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and review of the medical record, the facility failed to provide services to maintain hearing abilities for a sampled resident (#17) who complained of hearing loss, for 1 of 1 sampled	F 685	Based on observations, resident and staff interviews and review of the medical record, the facility failed to provide services to maintain hearing abilities for a sampled resident (#17) who complained	1/3/19

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F 685	Continued From page 17 resident reviewed. The findings included: Resident #17 was admitted to the facility on 8/17/15. Diagnoses included mild intellectual disabilities, anxiety, major depressive disorder, and mood disorder. Medical record review for Resident #17 revealed a psychiatric evaluation dated 4/4/18. The consult recorded that Resident #17 reported hearing loss when he stated, "I can't hear, my ears are clogged up." Further medical record review revealed a physician's (MD) standing order dated 4/20/18, which recorded "May be seen and treated by an audiologist." This order recorded a discontinue date of 9/26/18. There was no record of an audiology consult observed in the medical record. A quarterly minimum data set, dated 10/4/18, for Resident #17 assessed him with unclear speech, usually understood, understands, mild cognitive deficits, and minimal difficulty hearing. His October 2018 care plan identified a communication problem regarding a hearing deficit with interventions which included anticipate/meet needs, audiologist consult as needed and observe for and record any hearing impairment (ear discharge and cerumen/wax accumulation). Nurse aide (NA) #1 was observed on 12/2/18 at 4:26 PM to repeat herself several times during a conversation she had with Resident #17 after he said "huh?" to several questions/comments.	F 685	of hearing loss, for 1 of 1 sampled resident reviewed. F685 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; • Resident #17 identified during the survey as not having an Audiology appointment had an Audiology appointment on 12/17/18 • The nurse identified during the survey as not completing the Audiology referral received one-on-one in-service education, or will receive one prior to working a shift by the Director of Nursing regarding completion of referral appointments per MD/NP orders. • Completion 12/6/18 Address how corrective action will be accomplished for those residents having a potential to be affected by the same deficient practice; • All residents with an appointment referral by MD orders were identified. An Audit was completed on 12/26/18 by the Director of Nursing and Assistant Director of Nursing to determine whether the physician orders were followed to make the appointment. (Completion 1/3/19) • Referral appointments will be completed per the MD/NP orders, as well as psychiatrist evaluations to include the nurse signing off on the appointment orders, filling out the referral appointment form, giving the referral form to Medical Records to schedule the appointment as ordered by MD/NP. • EHR Designee will provide an	

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F 685	Continued From page 18 Resident #17 was interviewed on 12/02/18 at 4:46 PM. During the interview, several questions were repeated when he stated "huh?" and said "Sometimes when people talk to me, I can't hear them. I need some hearing aides. Will you help me?" During an interview on 12/05/18 at 9:00 AM, the social worker (SW) stated that she was working on identifying a community resource willing to pay for hearing aides for Resident #17 because of his complaints of hearing loss, inability to pay for them and a request for hearing aides. The SW further stated she was not aware of the status of the hearing aides. The SW also stated that in prior conversations with Resident #17, she had to repeat questions to him because of his difficulty hearing. A follow up interview with the SW occurred on 12/05/18 at 2:03 PM. She stated that she completed an initial application with a community agency regarding hearing aides for Resident #17 on 8/1/18. The SW stated she received an email response dated 8/27/18 which requested additional information to complete the application which included proof of NC residency, proof of income, a hearing test and an additional form. The SW then stated "I believe the hearing aid test was scheduled and completed, but I don't see the consult in his medical record, I will find out and get back to you." During an interview with NA #1 on 12/05/18 at 2:45 PM, she stated that Resident #17 had some hearing difficulty and at times she had to repeat questions/comments to him. NA #1 further stated that she was not aware of Resident #17 wearing or having hearing aides.	F 685	appointment list weekly for nurses and review the list during daily Stand-up meetings conducted by the Administrator. An updated referral appointment list will be provided to nurses and daily Stand-up meetings as appointments per MD/NP. (Completion 1/3/19) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur; • An in-service education will be completed for all licensed nurses and the EHR Designee by the Director of Nursing or RN designee to include following MD/NP orders and psychiatric evaluations for referral appointments (to include changes and cancellations). Any nurse who is unable to attend the mandatory in-service education by 1/3/19 will receive in-service education prior to working a shift. • Referral appointment forms will be checked daily by the Director of Nursing or designee as per MD/NP orders and psychiatric evaluations. • Director of Nursing or designee will report any new referral appointments made during daily Clinical and Stand-up meetings along with the MD/NP order and/or psychiatric evaluations. • MDS Care plans will be reviewed weekly to identify potential referrals/consultations that to need be scheduled. • Any issues identified will be corrected immediately and will also be taken to daily Stand-up meeting and reported to QAPI. • Completion 1/3/19	

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F 685	Continued From page 19 Nurse #1 stated in interview on 12/05/18 at 3:05 PM that Resident #17 had some hearing loss, but she had not observed him wearing hearing aides. The SW conducted an additional follow up interview on 12/06/18 at 9:32 AM. During the interview, the SW stated that when she received the community agency's request to have Resident #17 complete a hearing test back in August 2018 she forwarded the referral to nursing, who would be responsible to notify the scheduler to make the hearing test appointment. The SW stated it did not appear that the hearing test was scheduled because the scheduler did not receive the referral. An interview with the scheduler occurred on 12/06/18 at 9:35 AM and revealed that she was responsible to make resident appointments and arrange transportation once she received written referrals from nursing. The scheduler further stated that Resident #17 did not have a hearing test because she did not receive a referral to schedule an appointment until now. The director of nursing (DON) was interviewed on 12/06/18 at 10:16 AM and stated she expected staff to follow the process of ensuring that resident appointments were made. The DON stated that once a MD order was written, nursing was responsible to process the MD order, and provide a copy to the scheduler who was responsible to make the appointment and arrange transportation. The assistant director of nursing (ADON) was interviewed on 12/06/18 at 11:08 AM. During the	F 685	Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The PoC is integrated into the quality assurance system of the facility. • Director of Nursing or designee will audit 100% of residents with referral appointments (to include changes and cancellations) daily x 1 month, then weekly x 2 months to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and/or the Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency will be determined by the QAPI Committee.	

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F 685	Continued From page 20 interview, she stated that she processed Resident #17's standing MD order dated 4/4/18 for an audiology consult, but that standing orders were implemented as needed. She further stated she was not aware that Resident #17 complained of difficulty hearing during a psychiatric evaluation and further stated, "We should have activated that order and referred him for an audiology consult."	F 685		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to maintain safe hot water temperatures at or below 116 degrees Fahrenheit (F), with the maximum noted temperature obtained at 123.2 degrees F, for 6 shared resident bathrooms on 1 of 3 hallways (bathrooms for shared rooms 101/103, 102/104, 106/108, 110/112, 113/115, 114/116). The findings included: An interview with the Maintenance Supervisor on 12/2/18 at 4:59 PM, the supervisor reported he had been employed at the facility for two years. The Maintenance Supervisor reported he checked the water temperatures every	F 689	Based on observations, record review, and staff interviews, the facility failed to maintain safe hot water temperatures at or below 116 degrees Fahrenheit (F), with the maximum noted temperature obtained at 123.2 degrees F, for 6 shared resident bathrooms on 1 of 3 hallways (bathrooms for shared rooms 101/103, 102/104, 106/108, 110/112, 113/115, 114/116). F689 • Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Criswell Services Inc. was contracted to the facility on 12/2/18 to ensure that the	1/3/19

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F 689	Continued From page 21 Wednesday by a random selection of shared bathroom on each hall and both showers in the facility. The Maintenance Supervisor stated the goal was hot water temperatures range from 100 degrees F to 116 degrees F. The Maintenance Supervisor stated he had no reports the hot water temperature in the residents' bathrooms or in the shower rooms was too hot or uncomfortable and required adjustment. During the interview, the Maintenance Supervisor provided a log of hot water temperature checks. The log revealed the following temperatures for the month of November 2018: 11/7/18 at 10:17 AM adjoining bathroom for Rooms #101/103 water temperature 106.9 degrees F 11/7/18 at 10:29 AM bathroom for Room #204 water temperature 106.8 degrees F 11/7/18 at 10:55 AM bathroom for Room #304 water temperature 107.1 degrees F 11/14/18 at 2:05 PM adjoining bathroom for Rooms #101/103 water temperature 108.2 degrees F 11/14/18 at 2:15 PM bathroom for Room #202 water temperature 108.3 degrees F 11/14/18 at 2:18 PM bathroom for Room #304 water temperature 106.9 degrees F 11/21/18 at 11:15 AM bathroom for Room #304 water temperature 107.6 degrees F 11/21/18 at 11:22 AM adjoining bathroom for Rooms #206/208 water temperature 107.4 degrees F 11/21/18 at 11:36 AM adjoining bathroom for Rooms #101/103 water temperature 109.1 degrees F 11/28/18 at 11:30 AM adjoining bathroom for Rooms #114/116 water temperature 107.9 degrees F	F 689	hot water temperatures for all resident bathrooms were brought within the required temperature range of 100-116 degrees F. One-on-One in-service education was completed on 12/2/18 with the Maintenance Director to confirm the required hot water temperature range of 100-116 degrees F. Completion 12/2/18 • Address how corrective action will be accomplished for those residents having a potential to be affected by the same deficient practice; • Water temperatures will be randomly audited during alternating shifts (7am-3pm, 3pm-11pm, 11pm-7am) for 9 resident bathrooms and 2 shower rooms twice daily (am and pm) Monday-Sunday (“Manager on Duty” will be responsible for monitoring water temperatures on Saturday and Sunday) x 3 months and then weekly x 9 months, to ensure that hot water temperatures maintain acceptable parameters. If the Maintenance Director and/or designee (such as the Manager on Duty) identifies an out of range temperature, an “out of order” sign will be posted outside of the area ensuring residents do not use the water until proper temperatures are maintained. Criswell Services Inc. will continue to be contracted for both periodic, repair, and emergency maintenance. • Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur;	

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F 689	Continued From page 22 11/28/18 at 1:45 PM adjoining bathroom for Rooms #206/208 water temperature 107.4 degrees F 11/28/18 at 2:22 PM bathroom for Room #302 water temperature 107.6 degrees F On 12/2/18, a tour with the Maintenance Supervisor on the 100 Hallway revealed the following water temperatures: Digital readings with the facility's thermometer: On 12/2/18 at 5:10 PM, water temperature 117.3 degrees F in shared bathroom for 114/116. On 12/2/18 at 5:12 PM, water temperature 118.5 degrees F in shared bathroom for 113/115. On 12/2/18 at 5:13 PM, water temperature 123.2 degrees F in shared bathroom for 110/112. On 12/2/18 at 5:15 PM, water temperature 122.3 degrees F in shared bathroom for 101/103. On 12/2/18 at 5:19 PM, water temperature 123.1 degrees F in shared bathroom for 102/104. On 12/2/18 at 5:21 PM, water temperature 121.2 degrees F in shared bathroom for 106/108. Observation on 12/2/18 at 5:25 PM revealed the Maintenance Supervisor accessing the boiler in a utility space located just outside of the facility's rear staff entrance. The boiler thermostat was set at 118 degrees F. On 12/2/18 at 7:25 PM, an interview with Resident#58 in room#103, stated she had noticed the water in her bathroom sink to be hot and she adjusted temperature by adding cold water when she used the sink to wash her body in the morning. Resident#58 stated she has no injury related to hot water temperature. On 12/2/18 at 7:26 PM, an interview with	F 689	Water temperatures will be randomly audited during alternating shifts (7am-3pm, 3pm-11pm, 11pm-7am) for 9 resident bathrooms and 2 shower rooms twice daily (am and pm) Monday-Sunday (“Manager on Duty” will be responsible for monitoring water temperatures on Saturday and Sunday) x 3 months and then weekly x 9 months, to ensure that hot water temperatures maintain acceptable parameters. Criswell Services Inc. will continue to be contracted for both periodic, repair, and emergency maintenance. • Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The PoC is integrated into the quality assurance system of the facility. Maintenance Director or designee will audit water temperatures during alternating shifts (7am-3pm, 3pm-11pm, 11pm-7am) for 9 resident bathrooms and 2 shower rooms twice daily (am and pm) Monday-Sunday (“Manager on Duty” will be responsible for monitoring water temperatures on Saturday and Sunday) x 3 months and then weekly x 9 months, to ensure that hot water temperatures maintain acceptable parameters. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and/or the Director of Nursing on a daily basis and with QAPI	

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F 689	Continued From page 23 Resident#41 in room#104 stated she has not noticed water was hotter than a comfortable temperature. Resident#41 stated she used the sink independently to wash her hands and her body. Resident#41 stated she has no injury related to hot water temperature. On 12/2/18, during interviews with other alert and oriented residents on the 100 Hall, the residents reported no awareness of water temperatures in their bathrooms. The residents reported the sink was used by nurse aides. An interview with the Maintenance Supervisor on 12/02/18 at 7:34 PM, the supervisor stated he had not checked the water temperatures on second (3:00 PM - 11:00 PM) or third (11:00 PM - 7:00 AM) shifts. The Maintenance Supervisor further stated when he was on site on the weekends, he had visually checked the boiler thermostat but had not checked the water temperatures in the residents' bathrooms or the facility shower rooms. The Maintenance Supervisor stated the boiler was set at 118 degrees F prior to adjusting thermostat on the boiler. The Maintenance Supervisor stated the thermostat was set slightly higher than the recommended hot water temperature due to usage of hot water in the kitchen and throughout the facility. The Maintenance Supervisor stated the 100 Hall was closest to the boiler and most likely would have higher temperature readings. On 12/2/18 at 7:50 PM, the Maintenance Supervisor stated he adjusted the thermostat on the boiler and a tour of the shared resident bathrooms on the 100 Hall with water temperatures exceeding 116 degrees F revealed the following:	F 689	monthly for a period of 12 months.	

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F 689	Continued From page 24 Digital readings with the facility's thermometer: On 12/2/18 at 7:54 PM, water temperature 112.6 degrees F in shared bathroom for 101/103. On 12/2/18 at 7:57 PM, water temperature 113.5 degrees F in shared bathroom for 102/104. On 12/2/18 at 7:59 PM, water temperature 114.0 degrees F in shared bathroom for 106/108. On 12/2/18 at 8:02 PM, water temperature 108.5 degrees F in shared bathroom for 110/112. On 12/2/18 at 8:05 PM, water temperature 109.0 degrees F in shared bathroom for 113/115. On 12/2/18 at 8:07 PM, water temperature 108.2 degrees F in shared bathroom for 114/116. On 12/2/18 at 8:28 PM, an interview with the Director of Nursing (DON), the DON reported no concerns had been voiced by staff or residents regarding hot water temperatures in the facility nor had any resident incidents been attributed to hot water temperatures. On 12/2/18 at 8:32 PM, a review of facility incidents and environmental grievances revealed no concerns related to hot water temperature. An interview with the administrator on 12/05/18 at 2:49 PM, the Administrator stated he was notified on 12/2/18 of the temperature in the residents' bathrooms on the 100 Hall exceeded the regulation for hot water in facilities. The Administrator stated he expected the maintenance supervisor to monitor the hot water temperatures in the facility. The Administrator stated his expectation was the hot water temperature would satisfy state requirements.	F 689		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)	F 756		1/3/19

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F 756	Continued From page 25 §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. §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.	F 756		

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F 756	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on staff, pharmacist, nurse practitioner and physician interviews, and record review, the facility failed to identify the lack of documented blood pressure measurements used to monitor blood pressure medication for 1 of 5 sampled residents who received medication (Resident #38). The findings included: Resident #38 was admitted to the facility with diagnoses which included diabetes mellitus and hypertension. Review of Resident #38's monthly physician's orders dated 12/05/18 revealed renewal of orders (initiated November 2017) of direction to hold blood pressure medication administration for a systolic blood pressure measurement under 110 millimeters of mercury (mmHg). The physician ordered Metoprolol (used to treat high blood pressure) 25 milligrams twice daily (initial order date of November 2017). Review of Resident #38's October 2018 electronic medication administration record (eMAR) revealed direction to hold blood pressure medication for a systolic blood pressure measurement less than 110 mmHg. The eMAR documented of nurses' initials daily for blood pressure measurement. Weekly blood pressure measurements were documented on the eMAR. Further review of Resident #38's October 2018 eMAR revealed Resident #38's Metoprolol was held on 10/10/18 at 8:00 AM, on 10/18/18 at 8:00 AM and on 10/22/18 at 4:00 PM.	F 756	F756 Based on staff, pharmacist, nurse practitioner and physician interviews, and record review, the facility failed to identify the lack of documented blood pressure measurements used to monitor blood pressure medication for 1 of 5 sampled residents who received medications (Resident #38). • Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #38 identified during the survey as not having a blood pressure monitoring was corrected on 12/5/18. Nurse #3 and Nurse #4 identified during the survey as not recording the blood pressure for resident #38 received or will receive one-on-one in-service education prior to working a shift by the Director of Nursing on recording a blood pressure per MD/NP as ordered. Completion 12/5/18 • Address how corrective action will be accomplished for those residents having a potential to be affected by the same deficient practice; All residents with orders for documented blood pressure monitoring were identified. An audit was completed by the Director of Nursing or designee to determine whether the physicians' orders were followed to document blood pressures (completed on 12/5/18). Blood pressure monitoring documentation will be completed per the MD/NP orders to	

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F 756	Continued From page 27 Review of Resident #38's progress notes revealed documentation of blood pressure measurements for the held Metoprolol. Resident #38's blood pressure measured 90/55 mmHg on 10/10/18; 102/53 mmHg on 10/18/18 and 85/49 mmHg on 10/22/18. A progress note dated 10/21/18 documented the Metoprolol was held for a blood pressure measurement of 119/66 mmHg. Review of the monthly drug regimen review dated 10/24/18 revealed no recommendations or documentation regarding lack of blood pressure measurements. Review of Resident #38's November 2018 eMAR revealed direction to hold blood pressure medication for a systolic blood pressure measurement less than 110 mmHg. The eMAR documented of nurses' initials daily for blood pressure measurement. Weekly blood pressure measurements were documented on the eMAR. Further review of Resident #38's November 2018 eMAR revealed Resident #38's Metoprolol was held on 11/14/18 at 4:00 PM, on 11/22/18 at 4:00 PM and on 11/23/18 at 8:00 AM. Review of Resident #38's vital sign sheet revealed a blood pressure measurement of 100/66 mmHg documented on 11/22/18. There were no documented blood pressure measurements for the held medication on 11/14/18 and 11/23/18. Review of the monthly drug regimen review dated 11/29/18 revealed no recommendations or documentation regarding lack of blood pressure measurements.	F 756	include the nurse signing off the orders and adding supplementary documentation for blood pressure monitoring. Any resident with new orders for blood pressure monitoring will be reviewed daily during morning clinical meetings. Any issues identified will be corrected immediately and Administrator notified during daily Stand-up meetings. (Completion 1/3/19) • Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur; In-service education will be completed for all licensed nurses by the Director of Nursing or RN designee to include following MD/NP orders for documenting blood pressures. Any nurse who is unable to attend the mandatory in service by 1/3/19 will receive in-service education prior to working a shift. Director of Nursing and/or designee will review new orders for documenting residents blood pressures daily during morning clinical standup. Director of Nursing and/or designee will review blood pressure documentation as ordered by MD/NP in PCC daily. Any issues identified will be corrected immediately and will be taken to daily Stand-up meetings and reported to QAPI. Pharmacist will meet with the Director of Nursing during the monthly visit to identify any resident with blood pressure monitoring undocumented. (Completion 1/3/19) • Indicate how the facility plans to monitor its performance to make sure that	

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F 756	Continued From page 28 Interview with Nurse #4 on 12/04/18 at 3:42 PM revealed Resident #38 received blood pressure measurements prior to Metoprolol administration. Nurse #4 explained she documented the blood pressure measurement when the systolic was below 110 mmHg. Interview with Nurse #3 on 12/05/18 at 8:40 AM revealed she measured Resident #38's blood pressure prior to Metoprolol administration. Nurse #3 reported she documented the blood pressures on a shift report. Nurse #3 explained blood pressure measurements with a systolic measurement below 110 would be documented on the eMAR. Interview with the Director of Nursing (DON) on 12/05/18 at 8:43 AM revealed nurses documented Resident #38's blood pressure weekly and when the systolic measurement fell below 110 mmHg. The DON reported she expected staff to document each blood pressure measurement. Telephone interview with the consultant pharmacist on 12/05/18 at 12:12 PM revealed he reviewed blood pressure measurements for residents who received blood pressure medication. The consultant pharmacist could not provide a reason Resident #38's drug regimen reviews did not address the lack of documented blood pressure measurements. Interview with the nurse practitioner (NP) on 12/05/18 at 1:50 PM revealed she expected Resident #38's blood pressure measurements to be documented for assessment of blood pressure medication dose and frequency.	F 756	solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system of the facility. Director of Nursing or designee will audit 100% of residents with blood pressure monitoring 3x a week x 4, then 2x a week x 4, then 1x weekly ongoing to ensure compliance. Any issues identified will be corrected immediately. Results of the monitoring will be shared with the Administrator on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency will be determined by the QAPI Committee.	

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F 756	Continued From page 29 Interview with the physician on 12/05/18 at 1:54 PM revealed Resident #38's blood pressure measurements to be documented for medication review. The physician explained blood pressure measurements were used to monitor effectiveness of medication.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff, nurse practitioner and physician interviews, and record review, the facility failed to monitor a hemoglobin (Hgb.) A1c level and document blood pressure measurements to	F 757	F757 Based on staff, nurse practitioner and physician interviews and record review, the facility failed to monitor hemoglobin	12/30/18

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F 757	Continued From page 30 monitor diabetic and blood pressure medications for 1 of 5 sampled residents who received medication (Resident #38). The findings included: Resident #38 was admitted to the facility with diagnoses which included diabetes mellitus and hypertension. 1. Review of monthly physician's orders dated 12/05/18 revealed direction to obtain a Hgb. A1c every 3 months scheduled for January, April, July and October. (Hgb. A1c is a blood test used to measure the average level of blood sugar over the past 2 to 3 months.) The physician's orders included Januvia 100 milligrams daily and sliding scale NovoLog insulin twice daily. (Both medications are used to treat diabetes mellitus.) Review of Resident #38's laboratory tests revealed a Hgb. A1c result dated 07/30/18 of 9.2% with a reference range of 5.0% to 6.1%. There was no October 2018 Hgb. A1c result available for review. Interview with Nurse #3 on 12/04/18 at 10:47 AM revealed Resident #38's October 2018 Hgb. A1c result could not be located. Interview with the Assistant Director of Nursing (ADON) on 12/04/18 at 10:55 AM revealed the facility changed laboratory companies on November 1, 2018 and Resident #38's Hgb. A1c was not done. The ADON explained an audit of routine blood tests conducted at time of laboratory transition did not identify Resident #38's omitted Hgb. A1c.	F 757	(Hgb) A1c level and document blood pressure measurements to monitor diabetic and blood pressure medications for 1 of 5 sampled residents who received medication • Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #38 identified during the survey, blood pressure monitoring documentation was corrected on 12/5/18 Resident #38 hemoglobin (Hgb) A1c level drawn on 12/5/18 , reviewed by NP and put in resident's chart Assistant Director of Nursing received a one-on-one in-service education on 12/5/18. • Address how corrective action will be accomplished for those residents having a potential to be affected by the same deficient practice; All residents with a missing lab and blood pressure monitoring documentation were identified. An audit was completed by the Assistant Director of Nursing to determine if all labs were drawn, reviewed by MD/NP and put in resident's chart on 12/4/18. All residents identified will receive blood draws and blood pressure monitoring documentation for review by MD/NP to be completed by 1/4/19. Any resident with new orders for blood pressure monitoring and missed labs will be reviewed daily during morning clinical meetings. Any issues identified will be corrected immediately and Administrator notified during daily Stand-up meetings.	

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F 757	Continued From page 31 Interview with the Director of Nursing (DON) on 12/04/18 at 11:41 AM revealed she expected Resident #38's Hgb. A1c to be done as ordered. Interview with Resident #38's physician on 12/05/18 at 1:54 PM revealed the Hgb. A1c was ordered to monitor the efficiency of the diabetic medication. The physician reported he expected Resident #38's Hgb. A1c to be done as ordered. Interview with the ADON on 12/05/18 at 2:00 PM revealed Resident #38's Hgb. A1c drawn on 12/05/18 was 8%. 2. Review of Resident #38's monthly physician's orders dated 12/05/18 revealed renewal of orders (initiated November 2017) to hold blood pressure medication administration for a systolic blood pressure measurement under 110 millimeters of mercury (mmHg). The physician ordered Metoprolol (used to treat high blood pressure) 25 milligrams twice daily (initial order date of November 2017). Review of Resident #38's October 2018 electronic medication administration record (eMar) revealed direction to hold blood pressure medication for a systolic blood pressure measurement less than 110 mmHg. The eMAR documented of nurses' initials daily for blood pressure measurement. Weekly blood pressure measurements were documented on the eMAR. Further review of Resident #38's October 2018 eMAR revealed Resident #38's Metoprolol was held on 10/10/18 at 8:00 AM, on 10/18/18 at 8:00 AM and on 10/22/18 at 4:00 PM. Review of Resident #38's progress notes	F 757	• Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur; In-service education will be completed for all licensed nurses by the Director of Nursing and/or RN designee to include following MD/NP orders for labs and blood pressure monitoring, inputting lab orders into PCC, and putting labs with due dates in lab book. Any licensed nurse who is unable to attend the mandatory in-service education by 1/4/19 will receive the in-service education prior to working a shift. Assistant of Director of Nursing or designee will bring the lab book and lab results to morning clinical meetings daily for review. Labs will be reviewed by MD/NP with signatures. Labs will be given to Medical Records to put in residents chart. Director of Nursing or designee will review new orders for residents with new lab orders and blood pressure monitoring daily during morning clinical meetings to ensure compliance. MD/NP will be notified immediately of any labs that are missed and blood pressure monitoring that goes undocumented. Nurse identified as not following MD/NP orders will receive disciplinary action. Missed labs and blood pressure monitoring documentation will be shared with Administrator during daily Stand-up meetings. (Completion 1/4/19) • Indicate how the facility plans to monitor its performance to make sure that	

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F 757	Continued From page 32 revealed documentation of blood pressure measurements for the held Metoprolol. Resident #38's blood pressure measured 90/55 mmHg on 10/10/18; 102/53 mmHg on 10/18/18 and 85/49 mmHg on 10/22/18. A progress note dated 10/21/18 documented the Metoprolol was held for a blood pressure measurement of 119/66 mmHg. Review of Resident #38's November 2018 eMAR revealed direction to hold blood pressure medication for a systolic blood pressure measurement less than 110 mmHg. The eMAR documented of nurses' initials daily for blood pressure measurement. Weekly blood pressure measurements were documented on the eMAR. Further review of Resident #38's November 2018 eMAR revealed Resident #38's Metoprolol was held on 11/14/18 at 4:00 PM, on 11/22/18 at 4:00 PM and on 11/23/18 at 8:00 AM. Review of Resident #38's vital sign sheet revealed a blood pressure measurement of 100/66 mmHg documented on 11/22/18. There were no documented blood pressure measurements for the held medication on 11/14/18 and 11/23/18. Review of Resident #38's December 2018 eMAR revealed Resident #38's Metoprolol was held on 12/02/18. Review of a progress note dated 12/02/18 revealed a blood pressure measure of 105/55 mmHg. Interview with Nurse #4 on 12/04/18 at 3:42 PM revealed Resident #38 received blood pressure measurements prior to Metoprolol administration. Nurse #4 explained she documented the blood pressure measurement when the systolic was	F 757	solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The PoC is integrated into the quality assurance system of the facility. Director of Nursing or designee will audit 100% of residents with blood pressure monitoring documentation 3x a week x 4, then 2x a week x 4, then 1x weekly ongoing to ensure compliance. Director of Nursing or designee will audit labs daily during morning clinical meetings. Any issues identified will be corrected immediately. Results of the monitoring will be shared with the Administrator on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency will be determined by the QAPI Committee. All clinical staff received in-service education by the Director of Nursing or designee on 12/28/18 related to the importance of monitoring and inputting labs. Director of Nursing or designee will conduct audits of documentation specifically related to lab results weekly for 4 weeks. Any non-compliance will be reported to the Administrator and addressed immediately. On-going compliance will be monitored through the QA committee and noncompliance will be reported to the Administrator and addressed as appropriate.	

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	345304	A. BUILDING _____ B. WING _____	C 12/06/2018

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F 757	Continued From page 33 below 110 mmHg. Interview with Nurse #3 on 12/05/18 at 8:40 AM revealed she measured Resident #38's blood pressure prior to Metoprolol administration. Nurse #3 reported she documented the blood pressures on a shift report. Nurse #3 explained blood pressure measurements with a systolic measurement below 110 mmHg. would be documented on the eMAR. Interview with the Director of Nursing (DON) on 12/05/18 at 8:43 AM revealed nurses documented Resident #38's blood pressure weekly and when the systolic measurement fell below 110 mmHg. The DON reported she expected staff to document each blood pressure measurement prior to the Metoprolol administration. Interview with the nurse practitioner (NP) on 12/05/18 at 1:50 PM revealed she expected Resident #38's blood pressure measurements to be documented. The NP explained the measurements were used for assessment of blood pressure medication dose and frequency. Interview with the physician on 12/05/18 at 1:54 PM revealed Resident #38's blood pressure measurements should be documented for medication review. The physician explained blood pressure measurements were used to monitor effectiveness of blood pressure medication.	F 757		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals	F 761		1/3/19

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F 761	Continued From page 34 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to lock 1 of 3 medication carts when unattended and remove expired over-the-counter medications stored ready for use in 1 of 1 medication storage room. The findings included: 1. On 12/02/18 at 2:00 PM the weekend manager escorted the survey team to the facility's conference room. Observations made during that time revealed the medication cart on the 200 hall was unlocked and unattended. During the	F 761	F761 Based on observations and staff interviews, the facility failed to lock 1 of 3 medication carts when unattended and remove expired over-the-counter medications stored ready for use in 1 of 1 medication storage room • The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited;	

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F 761	Continued From page 35 observation, residents were seated in wheelchairs near the medication cart. The weekend manager locked the 200-hall medication cart. On 12/02/18 at 2:45 PM the weekend manager was interviewed about the unlocked medication cart and stated she locked the medication cart because it was unlocked, and she did not know where Nurse #2 was. On 12/02/18 at 3:22 PM Nurse #2 was interviewed about the medication cart. She explained she was assigned the 200 Hall medication cart and the cart worked fine, including the locking mechanism. The nurse stated she was trained to secure medications by locking the medication cart if the medication cart was going to be left unattended. The nurse stated it was an oversight for leaving the cart unlocked. On 12/05/18 at 10:00 AM the Director of Nursing (DON) was interviewed and stated she expected that when a nurse needed to step away from the medication cart that the cart be locked at all times. 2. On 12/02/18 at 3:18 PM observations of the 200-hall medication cart revealed the cart was unattended and unlocked. Residents were seated in wheelchairs near the medication cart. Nurse #2 was noted to be in a room behind a closed door. During the observation, the Assistant Director of Nursing (ADON) approached the medication cart and was asked to verify the medication cart was unlocked. The ADON locked the medication cart and reported it	F 761	Nurse #2 and weekend supervisor identified during the survey as not locking the medication cart received one- on- one in-service education by the Director of Nursing on 12/5/18. Facility failed to remove expired over-the-counter medications from storage room. • The procedure for implementing the acceptable plan of correction for the specific deficiency cited; In-service education will be completed for all licensed nurses by the Director of Nursing or designee regarding locking the medication cart when medication carts are left unattended. Any nurse who is unable to attend the mandatory in-service education by 1/3/19 will receive the in-service education prior to working a shift. In-service education will be completed for all licensed nurses and central supply personnel by the Director of Nursing or designee regarding removing expired medication from the storage room weekly by 1/3/19. Any issues identified will be corrected immediately and will also be taken to daily Stand-up meetings and/or reported to Administrator and QAPI. (Completion 01/3/19) • The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; the title of the	

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F 761	Continued From page 36 should not be left unattended and unlocked. On 12/02/18 at 3:22 PM Nurse #2 was interviewed about the medication cart. She explained she was assigned the 200 Hall medication cart and the cart worked fine, including the locking mechanism. The nurse stated she was trained to secure medications by locking the medication cart if the medication cart was going to be left unattended. Nurse #2 stated she asked another nurse to stand by the medication cart while she walked away but offered no explanation why the medication cart was left unattended. On 12/05/18 at 10:00 AM the Director of Nursing (DON) was interviewed and stated she expected that when a nurse needed to step away from the medication cart that the cart be locked at all times. 3. During a continuous observation on 12/05/18, the 200 Hall medication cart was first observed unattended and unlocked at 9:21 AM. No residents were near the medication cart or in the 200 Hallway. At 9:24 AM, the Director of Nursing (DON) approached the medication cart and verified the medication cart was unlocked. The DON locked the medication cart at this time. The DON was interviewed, and she stated her expectation was when a nurse stepped away from a medication cart, the cart should be locked by the nurse. On 12/05/18 as the observation continued, Nurse #6 returned to her assigned medication cart on the 200 Hall at 9:34 AM. Nurse #6 was interviewed regarding the unlocked medication cart. During the interview, the nurse explained	F 761	person responsible for implementing the acceptable plan of correction. Dates when corrective action will be completed. That corrective action dates must be acceptable to the State. Director of Nursing or designee will randomly audit medication carts to ensure they are locked 3x weekly for 4 weeks, then 2x weekly for 4 weeks, and then once per week for 4 weeks to ensure compliance. Director of Nursing or designee will randomly audit medication storage room weekly ongoing. Any identified issues will be corrected at that time and disciplinary action provided to the staff member. Results of the monitoring will be shared with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. • Completion 01/3/19	

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F 761	Continued From page 37	F 761		

she was asked by another nurse to assist in the medication storage room. The nurse stated she had been trained to secure medications by locking the medication cart if the medication cart was going to be left unattended. Nurse #6 stated she had not realized she left the medication cart unlocked while she assisted another nurse.

4. An observation was made on 12/2/2018 at 3:05 PM of the medication storage room with Nurse #5. Two bottles of expired over the counter (OTC) vitamins were identified- Vitamin A and Vitamin E. Each bottle had an expiration date noted as October 2018.

An interview with Nurse #5 on 12/2/2018 at 3:05 PM stated she would discard the vitamins due to them being expired. Nurse #5 stated the Central Supply clerk was responsible for checking for expired medications/ biologicals in the medication storage room.

An interview was completed with the Central Supply clerk on 12/4/2018 at 10:19 AM. The Central Supply clerk stated she and the nurses checked the medication storage room for inventory and expired medications (including vitamins) twice weekly. The Central Supply clerk further stated the nurse's checked the medication storage room for expired drugs. The Central Supply clerk verbalized the nurses would be responsible for discarding the medications/ biologicals if they were expired.

An interview was completed with the Director of

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F 761	Continued From page 38 Nursing (DON) on 12/9/2018 at 12:16 PM. The DON stated she expected her nurses, as well as, her Central Supply clerk to check for expired medications/ biologicals in the medication storage room on a weekly basis. The DON also stated she expected the pharmacy consultant to check the medication storage room during their monthly visit.	F 761		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions the committee put into place in January 2018. This was for a recited deficiency which was originally cited during a recertification survey completed December 2017. The deficiency was in the area of accident hazards. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: F689 Accident Hazards: Based on observations,	F 867	Based on observations, resident and staff interviews and record review, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions the committee put into place in January 2018. This was for a recited deficiency which was originally cited during a recertification survey completed December 2017. The deficiency was in the area of accident hazards. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance Program. F867 Address how corrective action will be accomplished for those residents found to	1/3/19

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F 867	Continued From page 39 record review, and staff interviews, the facility failed to maintain safe hot water temperatures at or below 116 degrees Fahrenheit (F), with the maximum noted temperature obtained at 123.2 degrees F, for 6 shared resident bathrooms on 1 of 3 hallways (bathrooms for shared rooms 101/103, 102/104, 106/108, 110/112, 113/115, 114/116). The facility was recited for F689, Accident Hazards, during the current recertification survey regarding failure to maintain safe hot water temperatures. F689 was originally cited during a recertification survey on 12/9/17 for failure to maintain safe hot water temperatures. During an interview with the administrator and director of nursing (DON) on 12/6/18 at 11:49 AM, the DON stated that when she assumed the role of DON at the facility in January 2018, she was made aware of the concern related to hot water, but no further concerns had been brought to her attention since January 2018. The administrator stated that he attributed a repeat deficiency related to accident hazards/safe hot water temperatures to a recent change in leadership and the need for continued accountability and monitoring.	F 867	have been affected or have the potential to be affected by the deficient practice; • The administrator will reeducate the Interdisciplinary team (IDT) and members of the Quality Assurance and Improvement Committee by 1/3/19 regarding accurately reporting and revising current action plans as well as developing and implementing new action plans to assure state and federal compliance in the facility. • IDT, including the facility Medical Director, will meet at least monthly to conduct the facility's Quality Assurance and Performance Improvement meeting. Should any IDT member find that the facility may need an Adhoc Quality Assurance and Performance Improvement meeting for a facility compliance issue, the Administrator will organize a meeting and notify all team members regarding the need to revise any present action plan or for the development of a new action plan to ensure compliance. • Completion 1/3/19 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur; • The administrator will reeducate the Interdisciplinary team (IDT) and members of the Quality Assurance and Improvement Committee by 1/3/19 regarding accurately reporting and revising current action plans as well as developing and implementing new action plans to assure state and federal compliance in the facility.	

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F 867	Continued From page 40	F 867	• IDT, including the facility Medical Director, will meet at least monthly to conduct the facility's Quality Assurance and Performance Improvement meeting. Should any IDT member find that the facility may need an Adhoc Quality Assurance and Performance Improvement meeting for a facility compliance issue, the Administrator will organize a meeting and notify all team members regarding the need to revise any present action plan or for the development of a new action plan to ensure compliance. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The PoC is integrated into the quality assurance system of the facility. • Quality Assurance monitoring will take place at each Quality Assurance and Performance Improvement meeting monthly and any Adhoc meetings held. This monitoring tool will be signed off by each IDT member after each meeting accepting and acknowledging all monitoring and revisions set forth by the Quality Assurance and Performance Improvement committee.	