STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345405	A. BUILDING _____ B. WING _____	C 12/20/2018

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CHARLOTTE HEALTH & REHABILITATION CENTER	1735 TODDVILLE ROAD CHARLOTTE, NC 28214

(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		1/17/19

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

Electronically Signed | 01/17/2019

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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 provide care in a manner to protect a resident's dignity who required assistance with incontinent care for 1 of 3 residents reviewed for dignity and respect (Resident #72). Findings included: Resident #72 was admitted on 2/1/2018. Resident #72's medical diagnoses were inclusive of unspecified bladder disorder and arthritis. Review of the quarterly Minimum Data Set (MDS) dated 11/30/18 revealed that Resident#72 was cognitively intact. Resident #72 required extensive assistance of one person with bed mobility, and total dependence of one person with toileting. Resident #72 had an external (condom) catheter and was always incontinent of bowel. No behaviors or rejection of care regarding ADL self-care performance deficit was noted during the assessment reference period. Resident #72's vision was noted to be adequate. Review of the care plan with a focus area for ADL self-care performance deficit, revised and dated 12/7/18, the care plan revealed Resident #72 required staff assistance and indicated a goal to maintain current level of function. Interventions included assist with toilet use and encourage the	F 550	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Bowel Incontinence care was provided for resident #72 on 12/17/2018. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All residents with bowel incontinence are identified as being at risk. At risk incontinent residents are identified by MDS section H. All residents with a BIMS of 12-15, bowel incontinence, and identified at risk will be interviewed regarding incontinent timeliness. Results will be reviewed by Director of Nursing for further problem resolution if needed Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not	

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F 550	Continued From page 2 resident to use bell to call for assistance. On 12/17/18 at 9:25 AM, Resident #72 was observed to be lying in bed awake. Resident #72 reported he notified nursing staff of his need to be changed due to bowel incontinence. Resident #72's room was odorous. The call light was observed to be off. Resident #72 reported he used the call light to notify staff of his need for incontinent care and a nursing staff member came in, turned the call light off, and informed him she would get someone to provide incontinent care. Resident #72 was unable to identify the staff member by name or identify if the staff member was a nurse or nurse aide. On 12/17/18 at 9:56 AM, Resident #72 was observed lying in bed and he reported no staff member had returned to assist him with incontinent care. The room was odorous at the time. On 12/17/18 at 11:23 AM, Resident#72 was lying in the bed, the room was odorous, and NA #1 was standing in the room in front of Resident #72's roommate's bed. Nurse Aide (NA) #1 stated she was preparing to provide incontinence care to Resident #72. On 12/17/18 at 4:23 PM, during an interview with Resident #72, he reported he had been changed by NA#1 and she reported to him, she had assisted another resident before providing incontinent care for him. Resident #72 stated the care was completed two and a half hours after he	F 550	recur; All Nursing staff will be educated on the timeliness of bowel incontinence care and to not turn off a call light until the patient care need has been met. Education will also be provided on resident rights including dignity with bowel incontinence care and timeliness of incontinence care requests. Education will be provided by the DON, SDC, or designee. Nursing staff who have not received education on or before 1/17/2019, will not be allowed to work until education is received. All New nursing staff will be educated during orientation on the timeliness of bowel incontinence care and to not turn off a call light until the patient care need has been met. Education will also be provided on resident rights including dignity with bowel incontinence care and timeliness of bowel incontinence care requests by Staff Development Nurse. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: 10% of residents with bowel incontinence and BIMs score 12-15 as identified on MDS section H will be interviewed by DON/UC/UM or designee for timeliness of bowel incontinence care. The interviews will be conducted 3x week x4 weeks, then monthly x 2 months. Interview and audit findings will be reported to Quarterly Quality Assurance and Improvement committee x1. The QAPI Committee will evaluate the effectiveness of the above plan, and will add additional interventions based on identified trends/outcomes to ensure continued compliance.	

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F 550	Continued From page 3 had made the request. Resident #72 stated NA#1 was not the staff member he made the request to and turned off the call light. Also, during the interview, Resident #72 described feeing "pitiful and helpless" while he waited for the nursing staff to perform incontinent care. Resident #72 stated he expected to have his needs met by either the nursing staff he informed and not have to wait for care for two and a half hours. Observations of Resident #72's room revealed a working clock was on the wall facing the resident's bed. On 12/19/18 at 3:10 PM, during an interview with NA#1, she stated she completed her morning rounds at the beginning of her assigned shift (7:00 AM - 3:00PM) on 12/17/18. NA#1 stated her rounds included an observation of assigned residents. NA#1 reported on 12/17/18 she was informed by her coworker Resident #72 had used his call light and requested incontinent care. NA#1 stated at the time of notification, she was in the process of providing care to another resident who required two-person assistance. NA#1 reported when she entered Resident #72's room, she first provided care to the roommate to allow the roommate to attend an activity. NA#1 stated next, she provided incontinent care for Resident #72. NA#1 reported Resident #72 was incontinent of bowel at the time of his care. On 12/19/18 at 5:22 PM during an interview with Unit Manager #1, the nurse reported her expectation for nursing staff was to provide residents with incontinent care at the time residents have notified nursing staff of their need for care and following the completion of a task	F 550	Include dates when corrective action will be completed. The Director of Nursing is responsible for ensuring the plan of correction is completed by January 17, 2019.	

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F 550	Continued From page 4 when involved in providing care for another resident. On 12/20/18 at 4:32 PM an interview was completed with the Director of Nursing (DON). The DON stated residents should not have to wait prolonged periods of time for incontinent care. The DON stated residents should be provided care within a reasonable amount of time, preferably within thirty minutes. The DON stated her expectation of staff would be to treat residents in a dignified manner.	F 550		
F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not	F 582		1/17/19

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F 582	Continued From page 5 covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide a Centers for Medicare and Medicaid Services (CMS) Notice of Medicare Non-Coverage and Skilled Nursing Facility Advanced Beneficiary Notice prior to discharge from Medicare Part A skilled services to 2 of 3 residents reviewed for beneficiary protection notification review (Residents #138, and #139).	F 582	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #138 expired on 6/30/2018 and Resident #139 discharged on 10/31/2018 Address how the facility will identify other residents having the potential to be affected by the same deficient practice:	

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F 582	Continued From page 6 Findings included: 1. Resident #138 was admitted to the facility on 5/18/2018. A review of the medical record revealed a CMS-10123 Notice of Medicare Non-Coverage letter (NOMNC) and a CMS-10055 SNF ABN (Skilled Nursing Facility Advanced Beneficiary Notice) were not issued to Resident #138 and/ or Resident #138's Responsible Party (RP) which explained Medicare Part A coverage for skilled services would end on 6/28/2018. An interview with the Regional Business Office Manager (RBOM) was completed on 12/18/2018 at 9:26 AM. The RBOM stated the company policy was to issue the NOMNC and SNF-ABN together. The RBOM stated she expected the resident and/ or family to be notified of the last covered day for services, and appeal rights to be explained and offered by the Business Office Manager (BOM). The RBOM further stated she expected for the appropriate notices to be issued by the BOM. An interview was completed with the Administrator on 12/19/2018 at 10:35 AM. The Administrator stated the expectation would be for the BOM or designee to issue the appropriate notices within the required time frame to the resident and/ or responsible party.	F 582	The Business Office Manager or Designee will audit all discharges within the past 30 days starting 1/10/2019, for the issuance of a NOMNC and SNF ABN. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Education was provided to the Business Office Manager on Business Office Policies & Procedures Policy #715. All residents who are discharged from Medicare Part A services will receive a CMS Notice of Medicare Non-Coverage (NOMNC) and Skilled Nursing Facility Advanced Beneficiary Notice (ABN) 48 hours before discharge, by the Business Office Manager or designee. Monday-Friday during daily IDT meeting, the issue date of NOMNCs and ABNs will be discussed and verified to be issued 48 hours before discharged. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: An audit of all discharges will be conducted weekly x 4 weeks and monthly x2 months, to verify a NOMNC and ABN are issued timely before a discontinuation of services. Audits will be conducted by the Administrator or designee and reviewed with the Quarterly Quality Assurance and Improvement Committee x 1. The QAPI Committee will evaluate the effectiveness of the above plan, and will add additional interventions based on identified trends/outcomes to ensure continued compliance.	

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F 582	Continued From page 7 2. Resident #139 was admitted to the facility on 9/3/2018. A review of the medical record revealed a CMS-10123 Notice of Medicare Non-Coverage letter (NOMNC) and a CMS-10055 SNF ABN (Skilled Nursing Facility Advanced Beneficiary Notice) were not issued to Resident #139 and/ or Resident #139's Responsible Party (RP) which explained Medicare Part A coverage for skilled services would end on 10/30/2018. An interview with the Regional Business Office Manager (RBOM) was completed on 12/18/2018 at 9:26 AM. The RBOM stated the company policy was to issue the NOMNC and SNF-ABN together. The RBOM stated she expected the resident and/ or family to be notified of the last covered day for services, and appeal rights to be explained and offered by the Business Office Manager (BOM). The RBOM further stated she expected for the appropriate notices to be issued by the BOM.	F 582	Completion date January 17, 2019	
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 staff interviews and medical record review, the facility failed to accurately code the annual Minimum Data Set (MDS) to indicate the Pre-Admission Screening and Annual Resident Review (PASRR) Level II status for 1 of 3	F 641	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The facility failed to accurately code the	1/17/19

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F 641	Continued From page 8 sampled residents reviewed (Resident #14). The findings included: Resident #14 was re-admitted to the facility 5/06/17. Diagnoses included schizoaffective disorder, congenital malformations of corpus callosum and development disorder of scholastic skills (intellectual disability). Review of a PASRR Level Determination Notification dated 6/29/17, revealed Resident #14 was currently considered by the State Level II PASRR process to have a serious mental and/or intellectual disability or a related condition. Review of the annual MDS dated 9/29/18, section A 1500, revealed the MDS coded that Resident #14 was not currently considered by the State Level II PASARR process to have a serious mental and/or intellectual disability or a related condition. During an interview on 12/20/18 at 1:45 PM the discharge planner (DCP) stated that she was responsible for the completion of section A of the MDS and that she completed section A 1500 on the annual MDS, for Resident #14. The DCP stated she made a mistake when she incorrectly coded the MDS to reflect that Resident #14 was not currently considered by the State Level II PASRR process to have a serious mental and/or intellectual disability or a related condition. She stated "I should have coded that he has a PASRR	F 641	Annual Minimum Data Set (MDS) to indicate the Preadmission Screening and Annual Resident Review (PASRR) Level II status 1 of 3 sampled residents reviewed (Resident #14). Resident #14□s Annual MDS 9/29/18 was modified on 1/14/19 to code Question A1500 correctly to indicate that resident was considered by the State Level II PASRR process to have a serious mental and/or intellectual disability or a related condition. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All current residents□ most recent comprehensive MDS considered by the state level II PASRR process to have serious mental illness and/or intellectual disability ("mental retardation" in federal regulation) or a related condition will be reviewed for correct coding according to the documentation from the residents□ medical records by Compliance Date of 1/17/19. Any issues identified as being coded incorrectly, will be modified by the MDSC/Discharge Planner. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Education was provided to the MDSC and DC Planner on 1/14/19 by the MDSC Regional Consultant on the RAI requirements for coding Question A1500 Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability ("mental retardation" in federal regulation) or a related condition? All new	

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F 641	Continued From page 9 Level II screen." An interview occurred on 12/20/18 at 1:47 PM with the director of nursing (DON). The DON stated that the DCP was responsible for completing section A of the MDS and that she expected the MDS to be completed accurately. The DON confirmed that section A 1500 of the annual MDS dated 9/28/18 for Resident #14 was coded inaccurately.	F 641	MDSC employees will be educated during orientation on proper coding of the Level II PASRR in Section A. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The MDS Consultant or designee will audit 5 residents□ MDS to ensure Question A1500 Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability ("mental retardation" in federal regulation) or a related conditions are correctly coded in Section A once weekly for 4 weeks, twice a month for one month, and monthly x 1 month. The findings will be reviewed at the Quarterly Quality Assurance and Improvement meeting X1 for further problem resolution. Date of Completion: January 17, 2019	
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires	F 645		1/17/19

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F 645	Continued From page 10	F 645		

the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services; or
(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing

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F 645	Continued From page 11 facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interviews and medical record review, the facility failed to refer a resident with a diagnosis of severe manic episodes with psychotic symptoms and a new diagnosis of schizophrenia for a Pre-Admission Screening and Annual Resident Review (PASRR) Level II screen for 1 of 3 sampled residents reviewed (Resident #16). The findings included: Resident #16 was admitted to the facility 5/23/18 with a PASRR Level I screen. Diagnoses on admission included anxiety disorder, severe manic episodes with psychotic symptoms and major depressive disorder. Review of Resident #16's care plan, dated 5/25/18, revealed the Resident exhibited adverse behavioral symptoms to include psychosis with paranoia, anxiety, hallucinations and behaviors (yelling, frequent request for medical transport,	F 645	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #16 received a new psychiatric diagnosis of schizophrenia while in the facility and a new Preadmission Screening and Resident Review (PASARR) Screen was not requested. A new PASARR was requested and a Level II was issued on January 4, 2019. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: An audit of all residents was conducted and residents that had received a new psychiatric diagnosis of schizophrenia since admission were referred for a PASARR screening by the Discharge Planner. Any residents that receive a new psychiatric diagnosis will be discussed during morning meeting with the IDT. Address what measures will be put into place or systemic changes made to	

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F 645	Continued From page 12 non-compliant with medications/nursing). Interventions included antipsychotic/antidepressant medication and psychiatric referrals. Review of the admission Minimum Data Set (MDS) dated 5/30/18 Section A 1500 indicted Resident #16 had not been evaluated by the State Level 2 PASRR process and determined to have a serious mental and/or intellectual disability or a related condition. The MDS also indicated daily use of antipsychotic and antidepressant medications. An initial Psychiatric Evaluation dated 6/2/18, indicated Resident #16 was being evaluated for psychosis related to increased paranoia, agitation, and behaviors (yelling/resisting care, requesting to leave facility as soon as possible). During the evaluation, Resident #16 reported increased depression, paranoia and auditory hallucinations. The evaluation included a recommendation to increase the dosage of current antipsychotic/antidepressant medications and a new diagnosis of schizophrenia. A follow up Psychiatric Evaluation for a medication check was completed 6/16/18 and noted that nursing staff reported Resident #16 continued to have hallucinations, paranoia, agitation and behaviors of refusing care/medications. During the follow up evaluation, Resident #16 was noted with paranoia symptoms and minimized staff's concerns with his behaviors.	F 645	ensure that the deficient practice will not recur: Education provided by Discharge Planner to Minimum Data Set Coordinator (MDSC), and administrative nurses regarding the need to refer residents for a PASARR screening when a new psychiatric diagnosis other that depression or anxiety is given to a resident during Quarterly Quality Assurance and Improvement meeting on January 10, 2019. The Discharge Planner will be responsible for initiating a PASARR screening. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Interdisciplinary Team will review residents during their ARD for a new psychiatric diagnosis other that depression or anxiety. If a resident is found to have one, the Discharge Planner will refer them for a PASARR screening. An audit will be completed weekly x4 weeks and monthly for 2 months by the MDSC or designee to confirm that new psychiatric diagnosis□ are communicated to the Discharge Planner and that a PASARR Screening was initiated. Audit findings will be reviewed X1 with the quarterly quality assurance and Improvement committee. The QAPI Committee will evaluate the effectiveness of the above plan, and will add additional interventions based on identified trends/outcomes to ensure continued compliance. Completion date January 17, 2019	

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F 645	Continued From page 13 During an interview on 12/20/18 at 1:44 PM the discharge planner (DCP) stated that she was responsible for the completion of section A of the MDS and that she completed section A 1500 on the admission MDS for Resident #16. The DCP stated she did not refer Resident #16 for a PASRR level II screen because he was admitted with a Level I screen. She further stated that she did not review diagnoses when she completed section A and she had never referred a resident for a Level II screen before. The DCP stated she reviewed the PASRR Level that was in place for a resident on admission, and stated, "They either come with a level I or level II, I am not sure who makes this referral, but I do not." An interview occurred on 12/20/18 at 1:47 PM with the director of nursing (DON). The DON stated that the DCP was responsible for making PASRR Level II referrals and confirmed that Resident #16 had not been referred for a PASRR Level II screen, but should have been due to his diagnoses and current treatment of severe manic episodes with psychotic symptoms and schizophrenia.	F 645		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review, the facility failed by	F 677	F677 Address how corrective action will be	1/17/19

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F 677	Continued From page 14 providing incontinent care for a resident after waiting for over two hours, for 1 of 3 dependent residents (Resident #72) reviewed for activities of daily living (ADL). Findings included: Resident #72 was admitted on 2/1/2018. Resident #72's medical diagnoses were inclusive of unspecified bladder disorder and arthritis. Review of the quarterly Minimum Data Set (MDS) dated 11/30/18 revealed that Resident#72 was cognitively intact. Resident #72 required extensive assistance, one-person assistance with bed mobility, and total dependence with one-person assistance for toileting. Resident #72 had an external (condom) catheter and was always incontinent of bowel. No behaviors or rejection of care regarding assistance with ADLs was noted during the assessment reference period. Resident #72's vision was noted to be adequate. Review of the care plan with a focus area for ADL self-care performance deficit, revised and dated 12/7/18, the care plan revealed Resident #72 required staff assistance and indicated a goal to maintain current level of function. Interventions included assist with toilet use and encourage the resident to use bell to call for assistance. On 12/17/18 at 9:25 AM, Resident #72 was observed to be lying in bed awake. Resident #72	F 677	accomplished for those residents found to have been affected by the deficient practice: Bowel Incontinence care was provided for resident #72 on 12/17/2018. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents with bowel incontinence are identified as being at risk. At risk incontinent residents are identified by MDS section H. All residents with a BIMS of 12-15, bowel incontinence, and identified at risk will be interviewed regarding incontinent timeliness. Results will be reviewed by Director of Nursing for further problem resolution if needed Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: All Nursing staff will be educated on the timeliness of bowel incontinence care and to not turn off a call light until the patient care need has been met. Education will also be provided on resident rights including dignity with bowel incontinence care and timeliness of incontinence care requests. Education will be provided by the DON, SDC, or designee. Nursing staff who have not received education on or before 1/17/2019, will not be allowed to work until education is received. All New nursing staff will be educated during orientation on the timeliness of bowel incontinence care and to not turn off a call light until the patient care need has been met. Education will also be provided on resident rights including	

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F 677	Continued From page 15 reported he notified nursing staff of his need to be changed due to bowel incontinence. Resident #72's room was odorous. The call light was off. Resident #72 reported he used the call light to notify staff of his need for incontinent care and a nursing staff member came in, turned the call light off, and informed him she would get someone to provide incontinent care. Resident #72 was unable to identify the staff member by name or identify if the staff member was a nurse or nurse aide. On 12/17/18 at 9:56 AM, Resident #72 was observed lying in bed and he reported no staff member had returned to assist him with incontinent care. The room was odorous at the time. On 12/17/18 at 11:23 AM, Resident#72 was lying in the bed, the room was odorous, and NA #1 was standing in the room in front of Resident #72's roommate's bed. NA #1 stated she was preparing to provide incontinence care to Resident #72. On 12/17/18 at 4:23 PM, during an interview with Resident #72, he reported he had been changed by Nurse Aide (NA)#1 and she reported to him, she had assisted another resident before providing incontinent care for him. Resident #72 stated the care was completed two and a half hours after he made the request. Resident #72 stated NA#1 was not the staff member he made the request to and turned off the call light. Also, during the interview, Resident #72 described feeing "pitiful and helpless" while he waited for	F 677	dignity with bowel incontinence care and timeliness of bowel incontinence care requests by Staff Development Nurse. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained 10% of residents with bowel incontinence and BIMs score 12-15 as identified on MDS section H will be interviewed by DON/UC/UM or designee for timeliness of bowel incontinence care. The interviews will be conducted 3x week x4 weeks, then monthly x 2 months. Interview and audit findings will be reported to Quarterly Quality Assurance and Improvement committee x1. The QAPI Committee will evaluate the effectiveness of the above plan, and will add additional interventions based on identified trends/outcomes to ensure continued compliance. Include dates when corrective action will be completed. Completion date January 17, 2019.	

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the nursing staff to perform incontinent care. Resident #72 stated he expected to have his needs met by the nursing staff he informed and not have to wait for care for two and a half hours. Observations of Resident #72's room revealed a working clock was on the wall facing the resident's bed.

On 12/19/18 at 3:10 PM, during an interview with Nurse Aide (NA), NA#1, she stated she completed her morning rounds at the beginning of her assigned shift (7:00 AM - 3:00PM) on 12/17/18. NA#1 stated her rounds included an observation of assigned residents. NA#1 reported on 12/1718 she was informed by her coworker Resident #72 had used his call light and requested incontinent care. NA#1 stated at the time of notification, she was in the process of providing care to another resident who required two-person assistance. NA#1 reported when she entered Resident #72's room, she first provided care to the roommate to allow the roommate to attend an activity. NA#1 stated next, she provided incontinent care for Resident #72. NA#1 reported Resident #72 was incontinent of bowel at the time of his care.

On 12/19/18 at 5:22 PM during an interview with Unit Manager #1, the nurse reported her expectation for nursing staff was to provide residents with incontinent care at the time residents have notified nursing staff of their need for care and following a task when involved in providing care for another resident.

On 12/20/18 at 4:32 PM during an interview with

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F 677	Continued From page 17 the Director of Nursing (DON), the DON stated her expectation was staff would provide incontinent care at the time of the request by residents or staff should request another staff member to aid with care. The DON stated she expected incontinent care to be provided within thirty minutes of an observation or notification of care required for a resident.	F 677		
F 689 SS=D	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, interviews with a resident (Resident #69), a technician and staff and review of facility records, the facility failed to maintain safe hot water temperatures at or below 116 degrees Fahrenheit (F) as evidenced by water temperatures identified from 118.2 - 119.7 degrees Fahrenheit (F) at resident hand sinks in bathrooms shared by 4 residents on 1 of 4 hallways (rooms 215, 216, 227, and 228). The findings included: An interview with the administrator on 12/16/18 at 5:00 PM revealed she assumed her role in the facility in September 2018. She stated that the	F 689	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 12/16/18 when hot water temperatures were found to be above 116 degrees, the hot water boiler was immediately adjusted to a lower temperature setting. Hot water was run under the supervision of department managers until hot water temperatures decreased to 116 degrees or below. Water temperatures were monitored in patients□ rooms hourly for 24 hours, 3x day for 1 week and daily thereafter. During these checks, the temperatures did not exceed 116 degrees. Address how the facility will identify other	1/17/19

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F 689	Continued From page 18 maintenance director was currently not in the facility. The administrator stated the maintenance director was the manager on duty (MoD) that day, she had called him, but she was unable to reach him. The administrator stated she was not aware of any resident concerns related to hot water and that she did not know what the safe water temperature range should be for resident use, she stated "I will have to check." The administrator rounded with the surveyor on 12/16/18 from 5:22 - 5:48 PM to check water temperatures at hand sinks in resident rooms on the 200 hall and the mechanical room using a facility thermometer that she verified for accuracy. The administrator obtained the following temperatures: Room 215, shared bathroom with room 216, 118.9 degrees F Room 228, shared bathroom with room 227, 118.2 degrees F Hot water tank in equipment room, gauge set to 126 degrees F, per administrator Mixing Valve "117 - 118" degrees F, per administrator An interview with Resident #69 (identified as alert/oriented per staff) occurred on 12/16/18 at 5:30 PM and revealed a couple weeks ago Resident #69 stated the hot water at the hand sink in her bathroom was too hot so she added cold water. Resident #69 denied being injured due to water that was too hot.	F 689	residents having the potential to be affected by the same deficient practice: Monday-Friday the Maintenance Director or designee will check water temperatures in locations accessible to patients, including 2 random patient rooms on each of the two units. Saturday and Sunday the Manager on Duty or designee will also check water temperatures in locations accessible to patients, including 2 patient rooms on each of the two units. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Maintenance Director received education on Maintenance Policies and Procedures Policy #203. The Maintenance Director will document daily temperature checks into the TELS system. A temperature log was created for the Manager on Duty to complete that addresses locations accessible to patients including 2 random patient rooms on each of the two units. All Department Managers responsible for fulfilling Manager on Duty duties were educated on the completion of this temperature log and that in the event temperatures exceed 116 degrees, the Maintenance Director and Administrator are to be notified immediately. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Administrator or designee will verify water temperatures are logged and within range of 100-116 degrees by auditing temperature logs weekly x4 weeks and	

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F 689	Continued From page 19 During an interview on 12/16/18 at 7:06 PM with the maintenance director he revealed he assumed his role in August 2018. He stated that he monitored water temperatures Monday - Friday, first thing in the morning, in the shower rooms, therapy, laundry, dietary and randomly checked hand sinks in resident bathrooms on each hall. He stated that the MoD was responsible for monitoring water temperatures on the weekends and added it was his weekend to be MoD, but he had not been in the facility that weekend, due to a family emergency, nor had he advised the administrator that he would not be in. He clarified that in his absence as MoD, the water temperatures had not been monitored that weekend. He further stated he was trained to monitor water temperatures for resident use at a safe range of "101-110" degrees F. The maintenance director further stated that he kept the gauge for the hot water tank set between 125-133 degrees F and adjusted the temperature range for the mixing valve as needed. The maintenance director then stated that last week residents voiced that the water in the shower rooms was too cold, so he adjusted the mixing valve temperature and increased the hot water tank temperature to 126 degrees F. The maintenance director rounded with the surveyor on 12/16/18 from 7:20 PM - 7:44 PM to check water temperatures at hand sinks in resident rooms on the 200 hall and the mechanical room using a facility thermometer that he verified for accuracy. When asked if he could explain the difference in temperature readings obtained approximately 2 hours earlier, the maintenance director stated "I have noticed for the last few weeks when I come in and check	F 689	monthly x2. Audit findings will be reviewed monthly with the Quality Assessment and Assurance Committee x3 months. The QAPI Committee will evaluate the effectiveness of the above plan, and will add additional interventions based on identified trends/outcomes to ensure continued compliance. Completion date January 17, 2019	

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the gauge at the hot water tank it is either higher/lower than the day before and the mixing valve the same, so I have just been making adjustments." He also clarified that he had not requested any repairs to heating/cooling equipment recently or reported this to the administrator. The maintenance director obtained the following temperatures:

Room 215, shared bathroom with room 216, 119.7 degrees F
Room 228, shared bathroom with room 227, 118.4 degrees F
Hot water tank in equipment room, gauge set to 130 degrees F, per maintenance director
Mixing Valve, "110" degrees Fahrenheit, per maintenance director

An interview occurred on 12/17/18 at 11:20 AM with the heating/cooling supervisor. He stated that he worked for a contractor that had serviced the facility for the past 10 years providing preventative maintenance biannually and repairs/consultation as needed. He stated that the facility's heating/cooling equipment had been serviced twice in 2018 with the last service in October 2018. He stated that in October 2018, he advised the maintenance director and faxed to the facility recommendations for repairs that had not been completed to date. He stated that the ignitor sensor was worn and needed to be replaced and that the temperature control switch was leaking which was an indicator of imminent failure.

A follow up telephone interview on 12/17/18 at

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4:25 PM with the heating/cooling supervisor revealed he replaced the temperature control gauge for the hot water tank because it was out of calibration and ordered parts for repairs he would complete once the parts came in. He further stated that he could not say definitively that the needed repairs contributed to the increased water temperatures at hand sinks in resident bathrooms, but that it was possible.

An interview with the administrator occurred on 12/17/18 at 11:43 AM. During the interview, the administrator stated that she assumed her role at the facility in September 2018. She provided documentation of facility temperature logs during the interview. The administrator stated that she had just reviewed the logs and replied "I have a lot of concerns regarding these temperature logs." The administrator stated the current maintenance director assumed his role in August 2018 and trained some with the previous maintenance director before he left, but she was not sure how much training he received. The administrator also stated that since September 2018, she verified that the maintenance director monitored and documented water temperatures, but she did not review the logs to verify exactly what the water temperatures were. She further stated "This is education for me, I was not made aware of any temperatures out of range, but I also did not check the logs for actual temperatures." The administrator also stated that she was not aware that when the heating/cooling supervisor serviced the heating/cooling equipment in October 2018, that he faxed recommendations for repairs. She stated, "We get hundreds of faxes per day, if we were not expecting a specific fax I would not have been

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looking for it." The administrator further stated that the maintenance director did inform her that he made temperature adjustments at the mixing valve, but that he did not tell her temperature adjustments were made because water temperatures exceeded 116 degrees F, nor did she ask. She also stated that there had been no injuries to residents as a result of water temperatures exceeding 116 degrees F.

Review of water temperature logs and incident/accident logs for September 2018 - December 2018, on 12/17/18 at 12:16 PM, revealed the following:

September 2018, no documentation of monitoring September 1 - 16 and September 22 - 30.
September 2018, temperatures recorded as:

- 9/17/18, 100 hall shower head B, 121 degrees F
- 9/17/18, 100 hall shower head C, 125 degrees F
- 9/17/18, 100 hall shower sink, 128 degrees F
- 9/17/18, 100 hall Resident room (no room documented), 125 degrees F
- 9/17/18, 200 hall shower head A, 125 degrees F
- 9/17/18, 200 hall shower head B, 121 degrees F
- 9/17/18, 200 hall shower head C, 124 degrees F
- 9/17/18, 200 hall shower sink, 128 degrees F
- 9/17/18, 200 hall shower room tub, 125 degrees F

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F 689	Continued From page 23 - 9/17/18, 200 hall Resident room (no room documented), 125 degrees F - 9/18/18, 100 hall, Resident room (no room number documented), 123 degrees F - 9/18/18, 100 hall shower head B, 120 degrees F - 9/18/18, 100 hall shower head C, 125 degrees F - 9/18/18, 100 hall shower sink 124 degrees F - 9/18/18, 200 hall shower room tub 124 degrees - 9/18/18, 200 hall, Resident room (no room number documented) 122 degrees F - 9/19/18, 100 hall shower head A, 117 degrees F - 9/19/18, 100 hall shower head B, 120 degrees F - 9/19/18, 100 hall shower head C, 126 degrees F - 9/19/18, 100 hall shower sink, 124 degrees F - 9/19/18, 100 hall Resident room (no room documented), 125 degrees F - 9/19/18, 200 hall shower head A, 129 degrees F - 9/19/18, 200 hall shower head B, 126 degrees F - 9/19/18, 200 hall shower head C, 126 degrees F - 9/19/18, 200 hall shower sink, 126 degrees F - 9/19/18, 200 hall shower room tub, 125 degrees F - 9/19/18, 200 hall Resident room (no room documented), 118 degrees F October 2018, no documentation of temperature	F 689		

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F 689	Continued From page 24	F 689		

monitoring October 1 - 14 and October 22 - 26. December 2018, no documentation of monitoring for December 1 - 2 and December 15.
Review of the incident/accident logs revealed no residents received injury as a result of water temperatures which exceeded 116 degrees Fahrenheit.

A follow up interview with the maintenance director on 12/17/18 at 12:25 PM revealed he assumed his role in August 2018 and he started monitoring water temperatures immediately. He stated he could not explain why he was missing documentation of monitoring for some dates, because he monitored temperatures routinely, but that he may have gotten some dates mixed up when he recorded the temperatures and may have missed checking temperatures on a few dates. He stated that he was trained "really quick" by the previous maintenance director by watching him check water temperatures. He further stated that the previous maintenance director explained to him what he was doing and stated, "I thought I was adequately trained at the time." The maintenance director further stated that he returned demonstration with checking water temperatures and he was trained that the water for resident use should be under 116 degrees F. He stated that if the water temperatures for resident use exceeded 116 degrees F he watched the previous maintenance director adjust the mixing valve and monitor temperatures, but never told him to report the adjustments to anyone. He further stated that when he identified water temperatures for resident use that exceeded 116 degrees F, "I just made adjustments and monitored temperatures, but did not report it." He stated he was not aware of any

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F 689	Continued From page 25 resident injuries or any resident complaints that the water temperatures were too hot. The maintenance director stated he was aware of the recommendations for repairs by the heating/cooling supervisor and reported it to the administrator.	F 689		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to administer medications with a 5% or less medication error rate as evidenced by 2 medication administration errors out of 25 opportunities for a medication error rate of 8% when medications were administered via gastrostomy tube (G-tube) and the physician order was to administer medications by mouth. (Resident #186) The findings included: Resident #186 was admitted to the facility on 12/5/18 with medical diagnoses inclusive of gastro-esophageal reflux disease and chronic obstructive pulmonary disease. A review of the physician medication orders revealed an order for Loratadine Tablet 10	F 759	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #186 had a G-tube and was also able to take PO intake. Resident #186 order was changed to give his medications by mouth. Nurse #1 reviewed the report sheet that stated Gt/PO as this was a new order for resident to start receiving meds via PO route instead of G-tube. Nurse #1 was educated after she administered the medications via G-tube. She was educated to make sure to follow doctor orders that were on the EMAR/TAR. Resident #186 complained of nausea when taking meds PO. Order obtained from Nurse Practitioner obtained to give meds via G-tube when resident was nauseated. Address how the facility will identify other residents having the potential to be	1/17/19

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F 759	Continued From page 26 milligrams by mouth one time a day and Potassium Chloride Extended Release 20 milliequivalents two tablets by mouth two times a day. The physician orders also included an order for medications to be crushed and administered together at one time for oral only. A medication administration was observed on 12/20/18 at 9:10 AM with Nurse #1. Nurse #1 prepared the medications for Resident #186 and crushed each tablet and opened the capsule. Medications were placed in individual medication cups. Nurse #1 entered Resident #186's room and informed him she was going to give him his medication via G-tube. Resident #186 informed Nurse #1 he no longer received his medication via G-tube due to the medication getting clogged in the tube. Nurse #1 informed Resident#186 she would attempt to successfully give the medication via his G-tube. Nurse #1 added normal saline to the crushed medication and contents from the capsule. During the medication administration, the G-tube would not allow the saline with the medication to flow through the tube via gravity. Nurse #1 used a declogger to allow the medication to go through the G-tube. Nurse #1 contacted Unit Manager #1 and informed her of her difficulty to administer Resident #186's medication via G-tube. On 12/20/18 at 10:03 AM, Unit Manger #1 and the Director of Nursing (DON) approached Nurse #1 and informed her Resident #186 was ordered to receive his medication by mouth. Unit Manager #1 also attempted to give Resident#186 his medication via G-tube. The DON attempted to give Resident #186 his medication via G-tube	F 759	affected by the same deficient practice: All current residents with G-tube orders will be audited for medication administration route. Report sheets will be updated for residents with G-tube for appropriate medication administration routes. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: All Licensed Nurses will be educated on five rights of medication administration including right dose, right person, right route, right medication and right time. Education will be completed by the DON, SDC or designee on or before January 17, 2019. Licensed Nurses who have not received education on or before January 17, 2019 will not be allowed to work until education is received. 100 percent licensed charge nurses will be observed completing med pass by SDC/DON/Designee All new licensed Nurses will be educated during orientation on five rights of medication administration including right dose, right person, right route, right medication and right time by Staff Development nurse. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Two licensed nurses will be audited on G-tube medication administration weekly by SDC/DON/Designee x 4 weeks then monthly x 2 months. No licensed nurse will be audited more than once until all licensed nurses have been audited.	

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F 759	Continued From page 27 when Unit Manager #1 was not successful. The DON used a declogger and was able to use gravity to allow for medication administration. Nurse #1 continued medication administration of crushed medications and contents from capsule until all medications were administered via G-tube. On 12/20/18 at 10:17 AM, Nurse #1 reported she had used the daily nurse sheet which identified Resident #186 received his medication via G-tube. Nurse #1 reported after the medication administration, she checked the electronic medication administration record that indicated medications were to be administered by mouth. Nurse #1 stated the medication order route changed on 12/16/18. On 12/20/18 at 2:29 PM, during an interview with the Nurse Practitioner (NP), the NP reported Resident #186 had difficulty receiving medications via G-tube and medication orders were changed to by mouth. The NP stated nursing reported the G-tube had clogged during medication administration. The NP voiced no concerns medications were administered via G-tube. NP gave orders to give medications via G-tube when nauseated following the medication administration on 12/20/18. On 12/20/18 at 2:43 PM, the DON stated she expected nurses to follow the five rights of medication administration and the policies set forth by the company and Nurse Practice Act. The DON stated the five rights included right dose, right person, right route, right medication, and	F 759	Results of the observations and audits will be reported to Quarterly Quality Assurance and Improvement committee x1. The QAPI Committee will evaluate the effectiveness of the above plan, and will add additional interventions based on identified trends/outcomes to ensure continued compliance. Completion date January 17, 2019.	

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F 759	Continued From page 28 right time. The DON stated she expected nurses to follow the doctor's orders.	F 759		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals 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 manufacturer's guidelines, observations and staff interviews, the facility failed to store medication in the original container in 3 of 4 medication carts (100A, 100B, and 200A), failed to date foil packaging for an inhalation solution in 1 of 4 medication carts	F 761	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: 3 out of 4 medication carts failed to store medications in original containers based	1/17/19

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F 761	Continued From page 29 (100A), failed to discard expired inhalation solution in 1 of 4 medication carts (100B), failed to discard an expired insulin pen in 1 of 4 medication carts (100B), and failed to label an inhaler in 1 of 4 medication carts (100B). Findings included: Review of the manufacturer's guideline for Ipratropium Bromide and Albuterol Sulfate Inhalation Solution read in part: Storage Conditions- Once removed from the foil pouch, the individual vials should be used within two weeks. Discard if the solution is not colorless. A. An observation was made of the 100A Medication Cart on 12/16/2018 at 12:48 PM which revealed six (6) vials of Ipratropium Bromide and Albuterol Sulfate Inhalation Solution, which were loose and outside of the original foil packaging. The six (6) vials and the foil packaging were not dated. Thirteen (13) unidentified loose pills, which ranged in size and color, were also observed in the bottom of the drawers throughout the medication cart. An interview with Nurse #2 on 12/16/2018 at 1:11 PM stated she has worked at the facility for over one (1) year. Nurse #2 stated medication carts were checked daily and it was every nurse's responsibility to check the medication carts on all shifts for expired medications and loose pills.	F 761	on manufacturer□s guidelines. 1 out of 4 carts failed to date foil package for inhalation solution, 1 out 4 failed to discard expired inhalation solution, 1 out of 4 failed to discard expired insulin pen and 1 out of 4 failed to label inhaler. All Medications found to be out of compliance were discarded immediately. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All medication carts were audited on 12/16/2018 and medications were discarded that were not in original packaging and not labeled. All medications that were expired were also discarded. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: All licensed nurses will be educated on storage of medications. Licensed nurses who have not received education on or before 1/17/2019 will not be allowed to work until education is received. Charge nurses are responsible for ensuring no medications are expired and all are labeled and dated appropriately. Charge nurses will be responsible for documenting their cart audit each shift x2 weeks. Charge nurses will be responsible for reporting their negative findings to the DON or Nurse Manager. All new licensed nurses will be educated on storage of medications during orientation by Staff Development nurse. Indicate how the facility plans to monitor its performance to make sure that	

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F 761	Continued From page 30 Nurse #2 did not indicate if she had checked the medication cart that day. Nurse #2 stated she would discard the six (6) vials of Ipratropium Bromide and Albuterol Sulfate Inhalation due to not being dated and outside the original foil packaging, and the thirteen (13) loose pills. An interview with the Director of Nursing (DON) on 12/16/2018 at 4:04 PM stated she expected all medications/ biologicals to be labeled, dated when opened, and stored in the original packaging by the nurses on the medication carts. B. An observation was made of the 100B Medication Cart on 12/16/2018 at 1:08 PM which revealed an unlabeled Ventolin HFA (Hydrofluoroalkane) inhaler in the first drawer of the medication cart, expired Ipratropium Bromide and Albuterol Sulfate Inhalation Solution (open date 10/19/2018), an expired Humalog kwikpen (date opened 11/15/2018), and eighteen (18) unidentified loose pills, which ranged in size and color, were also observed in the bottom of the drawers throughout the medication cart. An interview was completed with Nurse #3 on 12/16/2018 at 1:25 PM. Nurse #3 stated she worked as needed for the facility. Nurse #3 stated the medication cart was not her usual cart. Nurse #3 referred to facility guide for expiration time frames of insulin pens and stated the Humalog kwikpen was good for 28 days once opened. Nurse #3 did not indicate if she had checked the medication cart that day. Nurse #3 further stated she would discard the expired insulin pen, loose pills, expired Ipratropium	F 761	solutions are sustained: Shift audits will be conducted by the charge nurse during each shift x2 weeks. Medication carts will be audited by a member of the Nurse Management team 5X weekly x4 weeks, weekly x4 weeks then monthly x 10 months. Results of audits will be reported to Quarterly Quality Assurance and Improvement committee X1. The QAPI Committee will evaluate the effectiveness of the above plan, and will add additional interventions based on identified trends/outcomes to ensure continued compliance as needed. Completion date January 17, 2019	

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F 761	Continued From page 31	F 761		

Bromide and Albuterol Sulfate Inhalation Solution and the unlabeled inhaler.

An interview with the Director of Nursing (DON) on 12/16/2018 at 4:04 PM stated she expected all medications/ biologicals to be labeled, dated when opened, and stored in the original packaging by the nurses on the medication carts.

C. An observation was made of the 200A Medication Cart on 12/16/2018 at 1:34 PM which revealed five (5) unidentified loose pills, which ranged in size and color, were also observed in the bottom of the drawers throughout the medication cart.

An interview was completed with Nurse #4 on 12/16/2018 at 1:44 PM. Nurse #4 stated she has worked at the facility since May of 2018. Nurse #4 further stated medication carts were checked on nights (11-7 shift) once weekly for expirations. Nurse #4 explained that the medication cart can be easily managed when the rehabilitation unit is not full and there are less medication cards, but when the rehabilitation unit was full, the medication cards were hard to manage and pills would pop out. Nurse #4 stated she would discard of the loose pills.

An interview with the Director of Nursing (DON) on 12/16/2018 at 4:04 PM stated she expected all medications/ biologicals to be labeled, dated when opened, and stored in the original packaging by the nurses on the medication carts.

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F 812	Continued From page 32	F 812		
F 812 SS=D	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 resident and staff interviews, the facility failed to ensure two cartons of milk, with expired manufacturers' expiration dates, were not available for use or served to 1 of 1 residents reviewed for food safety. (Resident #29) The findings included: Resident #29 was admitted on 7/27/18 with medical diagnoses inclusive of gastroesophageal reflux disease with esophagitis, chronic obstructive pulmonary disease and chronic pain.	F 812	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 12/16/18, a resident reported that she received two expired milk cartons on her breakfast tray. The resident stated that both milk cartons had a use by date of 12/14/18. A CNA discarded the expired milk and brought the resident two new cartons of milk from the kitchen. The Dining Services Manager reviewed proper food storage procedures with all dining services staff working on 12/20/18.	1/17/19

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F 812	Continued From page 33 A review of the Minimum Data Set (MDS) noting a significant change dated 10/24/18 revealed Resident #29's cognition was moderately impaired. The MDS indicated Resident #29's vision was adequate. Resident #29 fed herself independently. During an interview on 12/16/18 at 11:40 AM, Resident #29 reported she received two expired milks for breakfast on 12/16/18. Resident #29 reported she requested the same breakfast each morning. Resident #29 stated she had two cartons of milk and two boxes of cereal for breakfast. Resident #29 reported on 12/16/18 she opened a carton of milk and poured it into a box of cereal. Resident #29 stated she tasted a spoonful milk and cereal and the taste was of sour milk. Resident #29 also reported she opened the second carton of milk and noticed the milk smelled sour. Resident #29 stated she informed the nursing staff the two cartons of milk were expired and requested more milk. Resident #29 stated the date on both milk cartons was 12/14/18. On 12/17/18 at 11:04 AM, Resident #29 stated she had no abdominal cramping, nausea, vomiting or diarrhea after having a spoonful of reported expired milk for breakfast on 12/16/18. On 12/17/18 at 11:20 AM, Nurse #2 stated she had not been informed of Resident #29 receiving expired milk during the breakfast meal on 12/16/18. Nurse #2 reported Resident #29 was a reliable informant and was able to recall specifics	F 812	Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All remaining dining services staff were in-serviced on proper food storage practices on 1/15/19. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Corporate Dietitian reviewed the above in-services with the Dining Services Manager to ensure they meet regulatory requirements on 1/15/2019. The Corporate Dietitian will monitor for proper food storage during her weekly facility visits X 4 and include this on her weekly visit report to Administration for further problem resolution if needed. The Dining Services Manager will audit food storage in all refrigerators weekly x 4 weeks, then monthly x 2 months to ensure deficient practice does not recur. Address how the facility plans to monitor its performance to make sure that solutions are sustained: Audit findings will be reported to Quarterly Quality Assurance and Improvement committee x1. The QAPI Committee will evaluate the effectiveness of the above plan, and will add additional interventions based on identified trends/outcomes to ensure continued compliance. Completion 1/17/19	

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F 812	Continued From page 34	F 812		

related to her care and her needs. Nurse #2 stated nurse aides have the responsibility to assist residents with request made regarding their meals.

On 12/19/18 at 4:40 PM during an interview with the Dietary Manager, she reported she worked the morning of 12/16/18 and had not been informed of a resident receiving expired milk. The Dietary Manager reported the facility received milk weekly and the new milk was placed under the milk crates in the facility's refrigerator. The Dietary Manager stated her expectation was the kitchen staff checked the expiration date of milk cartons in the crate before milk was served from the crate.

On 12/20/18 at 11:40 AM, NA #2 reported on 12/16/18, Resident #29 informed her the milk she received for breakfast was spoiled and expired. NA #2 stated she removed two cartons of milk from Resident #29's tray and requested two new cartons of milk from the kitchen staff. NA #2 stated she had not looked at the date on the milk cartons and had not informed kitchen staff the milk had been reported expired by a resident. NA #2 reported nurse aides were responsible for checking the meal slip for the correct diet and correct resident when serving the residents their meal tray. NA #2 stated she does not check expiration dates of food and liquid items on meal trays.

On 12/20/18 at 4:42 PM an interview was conducted with the Director of Nursing (DON). The DON stated she expected milk from the

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F 812	Continued From page 35 kitchen served to the resident not to be expired. The DON stated she had no expectation for nursing staff checking expiration dates of food and liquid items served to the residents when residents received trays from the kitchen. The DON stated she does expect nursing staff to assist with residents' request regarding their meal. On 12/20/18 at 4:53 PM an interview was conducted with the Administrator. The Administrator stated her expectation was food items and liquids served to the residents have not expired.	F 812		
F 835 SS=E	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with a resident (Resident #69), a technician and staff, review of medical records, facility records and manufacturer's guidelines, the facility's administration failed to provide management oversight to meet resident needs as evidenced by hot water temperatures in excess of 116 degrees Fahrenheit at hand sinks in 2 resident bathrooms shared by 4 residents. The facility's administration also failed to sustain an effective Quality Assessment Program through implemented procedures and monitoring of these interventions	F 835	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The facility will continue the plan of correction initiated for F689 and F761 " 3 out of 4 medication carts failed to store medications in original containers based on manufacturer□s guidelines. 1 out of 4 carts failed to date foil package for inhalation solution, 1 out 4 failed to discard expired inhalation solution, 1 out	1/17/19

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F 835	Continued From page 36 that the committee put into place during 2 federal surveys of record for 1 repeat deficiency in the area of labeling and storing drugs and biologicals. The findings included: This tag is cross referred to: 1. 483.25 (F689) Free of Accident Hazards/Supervision/Devices: Based on observations, interviews with a resident (Resident #69), a technician and staff and review of facility records, the facility failed to maintain safe hot water temperatures at or below 116 degrees Fahrenheit (F) as evidenced by water temperatures identified from 118.2 - 119.7 degrees Fahrenheit (F) at resident hand sinks in bathrooms shared by 4 residents on 1 of 4 hallways (rooms 215, 216, 227, and 228). An interview with the administrator occurred on 12/17/18 at 11:43 AM. During the interview, the administrator stated that she assumed her role at the facility in September 2018. She provided documentation of facility temperature logs during the interview. The administrator stated that she had just reviewed the logs and replied " I have a lot of concerns regarding these temperature logs." The administrator stated the current maintenance director assumed his role in August 2018 and trained some with the previous maintenance director before he left, but she was not sure how much training he received. The administrator also stated that since September 2018, she verified that the maintenance director	F 835	of 4 failed to discard expired insulin pen and 1 out of 4 failed to label inhaler. All Medications found to be out of compliance were discarded immediately. " On 12/16/18 when hot water temperatures were found to be above 116 degrees, the hot water boiler was immediately adjusted to a lower temperature setting. Hot water was run under the supervision of department managers until hot water temperatures decreased to 116 degrees or below. Water temperatures were monitored in patients rooms hourly for 24 hours, 3x day for 1 week and daily thereafter. During these checks, the temperatures did not exceed 116 degrees. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All medication carts were audited on 12/16/2018 and medications were discarded that were not in original packaging and not labeled. All medications that were expired were also discarded. Monday-Friday the Maintenance Director or designee will check water temperatures in locations accessible to patients, including 2 random patient rooms on each of the two units. Saturday and Sunday the Manager on Duty or designee will also check water temperatures in locations accessible to patients, including 2 patient rooms on each of the two units. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not	

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F 835	Continued From page 37 monitored and documented water temperatures, but she did not review the logs to verify exactly what the water temperatures were. She further stated "This is education for me, I was not made aware of any temperatures out of range, but I also did not check the logs for actual temperatures." The administrator also stated that she was not aware that when the heating/cooling technician serviced the hot water tank in October 2018, that he faxed recommendations for repairs. She stated, "We get hundreds of faxes per day, if we were not expecting a specific fax I would not have been looking for it." The administrator further stated that the maintenance director did inform her that he made temperature adjustments at the mixing valve, but that he did not tell her temperature adjustments were made because water temperatures exceeded 116 degrees F, nor did she ask. 2. 483.45 (F761) Label/ Store Drugs and Biologicals: Based on manufacturer's guidelines, observations and staff interviews, the facility failed to store medication in the original container in 3 of 4 medication carts (100A, 100B, and 200A), failed to date foil packaging for an inhalation solution in 1 of 4 medication carts (100A), failed to discard expired inhalation solution in 1 of 4 medication carts (100B), failed to discard an expired insulin pen in 1 of 4 medication carts (100B), and failed to label an inhaler in 1 of 4 medication carts (100B). An interview on 12/20/2018 at 5:25 PM with the Administrator revealed that medication storage continued to be an area that the facility evaluated and discussed at the monthly QAA meeting. The	F 835	recur: All licensed nurses will be educated on storage of medications. Licensed nurses who have not received education on or before 1/17/2019 will not be allowed to work until education is received. Charge nurses are responsible for ensuring no medications are expired and all are labeled and dated appropriately. Charge nurses will be responsible for documenting their cart audit each shift x2 weeks. Charge nurses will be responsible for reporting their negative findings to the DON or Nurse Manager. The Maintenance Director received education on Maintenance Policies and Procedures Policy #203. The Maintenance Director will document daily temperature checks into the TELS system. A temperature log was created for the Manager on Duty to complete that addresses locations accessible to patients including 2 random patient rooms on each of the two units. All Department Managers responsible for fulfilling Manager on Duty duties were educated on the completion of this temperature log and that in the event temperatures exceed 116 degrees, the Maintenance Director and Administrator are to be notified immediately. The Administrator was educated on the monitoring and management oversight of water temperature documentation, as well as maintaining an effective Quality Assessment Program through implemented procedures and monitoring interventions. Indicate how the facility plans to monitor	

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F 835	Continued From page 38 Administrator stated that the repeated deficiency in medication storage could be attributed to the need for continued education and monitoring for the nursing staff.	F 835	its performance to make sure that solutions are sustained Shift audits will be conducted by the charge nurse during each shift x2 weeks. Medication carts will be audited by a member of the Nurse Management team 5x weekly x4 weeks, weekly x4 weeks then monthly x 10 months. Results of audits will be reported to Quarterly Quality Assurance and Improvement committee x 3. The QAPI Committee will evaluate the effectiveness of the above plan, and will add additional interventions based on identified trends/outcomes to ensure continued compliance. The Administrator or designee will verify water temperatures are logged and within range of 100-116 degrees by auditing temperature logs weekly x4 weeks and monthly x3 months. Audit findings will be reviewed monthly with the Quarterly Quality Assurance and Improvement Committee x 3. The QAPI Committee will evaluate the effectiveness of the above plan, and will add additional interventions based on identified trends/outcomes to ensure continued compliance. Completion January 17, 2019	
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	F 867		1/17/19

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F 867	Continued From page 39 by: Based on record review and staff interview the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in February 2018. This was for one recited deficiency, F761, which was originally cited in February 2018 during an annual recertification and was subsequently recited in April 2018 on an on-site follow up survey and complaint investigation. The deficiency was in the area of label/ store drugs and biologicals. 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. The findings included: This tag is cross referenced to: 483.45 (F761) Label/ Store Drugs and Biologicals: Based on manufacturer's guidelines, observations and staff interviews, the facility failed to store medication in the original container in 3 of 4 medication carts (100A, 100B, and 200A), failed to date foil packaging for an inhalation solution in 1 of 4 medication carts (100A), failed to discard expired inhalation solution in 1 of 4 medication carts (100B), failed to discard an expired insulin pen in 1 of 4 medication carts (100B), and failed to label an inhaler in 1 of 4 medication carts (100B). During the annual recertification survey	F 867	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: 3 out of 4 medication carts failed to store medications in original containers based on manufacturer□s guidelines. 1 out of 4 carts failed to date foil package for inhalation solution, 1 out 4 failed to discard expired inhalation solution, 1 out of 4 failed to discard expired insulin pen and 1 out of 4 failed to label inhaler. All Medications found to be out of compliance were discarded immediately. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All medication carts were audited on 12/16/2018 and medications were discarded that were not in original packaging and not labeled. All medications that were expired were also discarded. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: All licensed nurses will be educated on storage of medications. Licensed nurses who have not received education on or before 1/17/2019 will not be allowed to work until education is received. Charge nurses are responsible for ensuring no medications are expired and all are labeled and dated appropriately. Charge nurses will be responsible for documenting their cart audit each shift x2 weeks. Charge nurses will be responsible	

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F 867	Continued From page 40 conducted 12/20/2018, the facility was recited for not properly labeling, storing and discarding expired medications in 3 of 4 medication carts. An interview on 12/20/2018 at 5:25 PM with the Administrator revealed that she completed monthly QAA meetings with her administrative team. The Administrator verbalized that medication storage continued to be an area that the facility evaluated and discussed at the monthly QAA meeting. The Administrator stated that the repeated deficiency in medication storage could be attributed to the need for continued education and monitoring for the nursing staff.	F 867	for reporting their negative findings to the DON or Nurse Manager. All new licensed nurses will be education on storage of medications during orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Shift audits will be conducted by the charge nurse during each shift x2 weeks. Medication carts will be audited by a member of the Nurse Management team X5 weekly x4 weeks, weekly x4 weeks then monthly x 10 months. Results of audits will be reported to QAA committee x 12 months. The QAPI Committee will evaluate the effectiveness of the above plan, and will add additional interventions based on identified trends/outcomes to ensure continued compliance. Completion date January 17, 2019	