STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345434	A. BUILDING _____ B. WING _____	C 01/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER LIVING CENTER	303 EAST CARVER STREET DURHAM, NC 27704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification survey was conducted on 01/07/19 through 01/11/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 1U4M11.	E 000		
F 550 SS=E	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	F 550		2/7/19

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

Electronically Signed | 02/06/2019

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F 550	Continued From page 1 resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record reviews the facility failed to ensure residents dignity was maintained by not covering the bodies of 2 of 2 cognitively impaired sampled residents (Resident #118 and #126) to prevent exposure of their bodies to others and failed to serve meals at the same time for 1 for 19 residents (Resident #30) observed eating in the dining room. The Findings included: 1. Resident #118 was admitted on 11/13/18 with diagnosis of: congestive heart failure, type two diabetes, major depressive disorder. Review of Resident #118's Minimum Data Set dated 8/23/18 a quarterly review revealed the resident was mildly cognitively impaired. Resident needed extensive assistance of 1-2 people for all activities of daily living (ADL), only needed to be set up for meals. Resident was incontinent of bowel and bladder. The review of the care plan for Resident #118 dated 2/25/18 revealed the resident was care planed for activities of daily living related to limited physical mobility due to heart failure and	F 550	Resident #118 was dressed by the Certified Nursing Assistant (CNA) on 1/8/19, when she was made aware that the resident was undressed. The Director of Nursing (DON) provided education to the nursing staff completed on 01/23/2019, regarding dignity and assuring residents are properly dressed. Resident #30 received her requested meal on 1/8/19. The DON provided education to the nursing staff completed on 02/08/2019, regarding providing meals consecutively for residents sitting together at a table. Dietary manager provided education completed on 02/07/2019 for dietary staff regarding providing trays for residents timely to reduce the risk of residents not receiving trays consecutively. Resident #126 was dressed by the CNA on 1/8/19, when she was made aware that the resident was undressed. The DON provided education to the nursing staff completed on 01/23/2019, regarding dignity and assuring residents are properly dressed.	

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F 550	Continued From page 2 diabetes, comfort care, cognitive deficits. The goals included: staff will provide assistance with activities of daily living (ADL) while maintaining resident's dignity and the staff will anticipate resident's daily needs. Interventions included with assistance of one person to provide all ADL care, anticipating and meeting resident's needs. Cue, reoriented and/or supervisor resident as needed. On 1/8/19 at 1:55 pm resident was observed lying in bed with only a diaper on, door was shut into room. Resident did answer when name called, she was unable to state why she did not have any clothes on. The resident was observed covering her breast with her arms. Observation also revealed that the privacy curtain was not drawn. During an observation and interview with Nurse # 9 on 1/8/19 at 2:14 pm, nurse indicated Resident #118 sometimes pull her clothes off. Nurse #9 looked around the and the gown was not found. Nurse also stated that it the responsibility of nursing aide to make rounds every 20 minutes to ensure the resident was properly dressed. On 1/8/19 at 2:25 pm Nurse #8 was interviewed and he stated that the nursing aide were to make rounds every 2 hours and he does not know why the resident doesn't have any clothes on and only a diaper. He also stated that he will talk with the nursing aides. During an interview with the Director of Nursing (DON) on 1/8/19 at 2:32 pm she was informed of the resident being left with only a diaper on and no covers to cover herself with. The DON stated that she would talk with the unit manager, LPN and nursing aide. She also stated that the nursing	F 550	Current cognitively impaired facility residents have the potential to be affected by the alleged deficient practice of not providing coverage to resident bodies to ensure dignity and prevent exposure of their bodies to others. Current facility residents that eat in the dining room areas have the potential to be affected by the alleged deficient practice of failing to receive meals consecutively while sitting with other residents in the dining areas. The Assistant Director of Nursing completed in-service education on 2/01/19, for licensed nurses and certified nursing assistants regarding maintaining dignity related to assuring residents are dressed to prevent exposure of their bodies to others and provision of meal trays consecutively at dining tables. The Dietary Manager completed education on 2/05/19 through 02/07/19, regarding provision of meal trays to assure residents receive meal trays consecutively at the dining table. No direct care staff will return to work prior to receiving in-service education. New staff will be in-serviced during new hire orientation regarding residents□ rights including dignity and dining experience. The Director of Nursing, ADON, Unit coordinator and/or Dietary Managers will monitor dining areas to ensure trays are served consecutively at each table for	

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F 550	Continued From page 3 aides were to make rounds every two hours, and since it was around lunch time, the aides should have been in the room more. In an interview with Nursing Aide # 8 on 1/9/19 at 1:38 pm, she stated that checks were conducted on the residents every 2 hours. She confirms that sometimes the resident takes her clothes off. She also stated that "if the resident did not have any clothes on", she put their clothes or a gown back on and she does not know why a resident would not have any clothes on unless the resident took them off. 2. Resident #30 was admitted on 5/22/18 with diagnosis that included diabetes and dementia. A review of Minimum Data Set a quarterly assessment dated 10/1/18 revealed that the resident was mildly cognitively impaired. The resident required extensive assistance with one-person assistance for all activities of daily living. Observation made of the dining room #1 on 1/8/19 at 4:55 pm showed residents being served individually instead on each table being served at the same time. Resident #30 waited 45 minutes to be served. Three staff members asked her what she wanted to eat they then informed the kitchen staff, which did not deliver her food until residents were finished eating. In an interview with Resident #30 on 1/8/19 at 5:45 pm, she stated that she has waited a long time before to receive her meal on other occasions. She did say that it did bother her sometimes.	F 550	residents who dine in the dining areas 5 times a week for 2 weeks, then 3 times a week for 2 months The DON and/or the Dietary manager will review the audits/monitors monthly to identify patterns/trends and will adjust plan as necessary. The plan will be reviewed during the monthly QAPI meeting and audits/monitors will continue at the discretion of the QAPI committee. Director of nursing, ADON, unit coordinators will monitor/observe 20 residents a week for 4 weeks then 20 residents a month for 2 months to ensure dignity is provided to the residents as evidenced by residents are dressed and privacy curtains and blinds are closed during care. The DON and/or the ADON will review the monitors monthly to identify patterns/trends and will adjust the plan as necessary. The plan will be reviewed during the monthly QAPI meeting and audits/monitors will continue at the discretion of the QAPI committee.	

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F 550	Continued From page 4	F 550		

During an interview with the executive chief on 1/11/19 at 8:40 pm he stated that he cannot give the resident some to eat without checking what her diet is first. He also stated with this resident he had to find her meal request before she could be served because he did not want to give her something she is not to have. The chef stated he was unable to state why the meal ticket had not been found.

3. Resident #126 was admitted to the facility on 9/10/18 with diagnoses that included cerebellar stroke syndrome, chronic respiratory failure, symptoms and signs of cognitive function and awareness.

Review of the recent updated care plan dated 10/3/18 revealed the resident was care planned for activities of daily living (ADL) needing total to extensive assistance due to poor cognition and for behavior problem (pulling off clothes and brief). Goals indicate the resident no complications related to ADL dependence. Staff are to reapply torn brief/clothing. Interventions included were providing total assistance with all ADL's. Anticipate and meet the resident's needs. Staff are to intervene as needed and when resident pulls out his gastrostomy tube (GT).

A review of the most recent Minimum Data Set (MDS) assessment dated 11/2/18 marked as a quarterly assessment, revealed resident was assessed as severely cognitively impaired. The assessment indicated resident was total dependence with one-person assistance for activities of daily living (ADL). Resident was coded as always having bowel and bladder incontinence.

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F 550	Continued From page 5	F 550		

During an observation on 1/8/19 at 9:54 AM, the door to Resident #126's room was open. Resident # 126 was observed from the room's doorway lying in bed, wearing no gown or clothes, the lower half of the resident's body was covered by a bed spread. The resident's brief was visible from the side. Observations revealed the privacy curtain was not drawn around the resident's bed. Interview with Nurse Aide (NA) #2 at this time revealed the resident frequently pulled off his gown and pulled at his brief. Nurse Aide #2 was unsure why resident was not wearing a gown. She further stated the resident was currently a single occupant in the room and hence the privacy curtain was not drawn.

Observation from Resident #126 room's doorway on 1/8/19 at 1:51 PM revealed Resident #126 was lying in bed on his back with only the corner of the bed spread covering his perineal area. Resident #126 was not wearing any clothes or gown. Interview with Nurse #1 at this time revealed the resident should be covered with the gown and further stated that she was unsure why the NA had not assisted the resident with dressing. Nurse aides are responsible to check on the residents every 2 hours. Nurse #1 could not find any gowns in the resident's room.

During an interview on 1/ 8/19 at 2:25 PM, Nurse #5 (unit manager) stated the resident exhibit behaviors of pulling his clothes and undergarments. Nurse #5 further stated the resident's behavior should not be reason for the resident to be covered with only the corner of the bed spread. Nurse #5 stated it was her expectation the resident was dressed appropriately by staff.

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F 550	Continued From page 6 During an interview on 01/11/19 at 8:00 PM, Director of Nursing (DON) stated Resident #126 should be frequently checked by staff during their shift as the resident exhibited behavior of pulling off his clothes. The DON further stated the expectations were always to have the resident properly dressed and privacy provided to the resident by closing blinds and curtains during care.	F 550		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F 584		2/6/19

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F 584	Continued From page 7 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and maintenance records, the facility failed to clean resident rooms and repair broken items in resident rooms. The facility also failed to maintain a clean and sanitary linen closet for 2 of the 4 closet and failed to change soiled linens for 1of 1 resident reviewed for a clean and homelike room (Resident # 19). Findings included: 1. Resident room #305 On 1/ 7/19 at 2:00 pm observation the threshold between the bathroom and the room is missing. Leaving a 2-inch opening between the floors. During an interview with housekeeping staff (HKS) on 1/11/19 at 8: 35 am, she stated that she is to report any damage or missing parts in the facility to either to the maintenance department or to the nurse, so she can notify maintenance department. She also stated that she had not reported it yet.	F 584	The facility Maintenance Director ordered the threshold replacements on 01/07/2019. Facility Maintenance Director replaced the threshold for resident room # 305 on 01/14/2019. Resident rooms #129 and #306 were cleaned by housekeeping on 01/11/2019, to include cleaning bed frame, under bed and floors to remove dust, dirt, spills and trash. Resident # 19 room #111, had bed linens changed on 01/07/2019. The housekeeping supervisor cleaned and organized the linen closet on 100 hall on 01/11/2019. The housekeeping supervisor cleaned and organized the linen closets between 100 and 200halls on 01/11/2019. Current facility residents have the potential to be affected by the alleged	

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F 584	Continued From page 8 In an interview with the Maintenance Director on 1/10/19 at 9:00 am, he stated that the cover for the threshold was on back order. However, he did produce an invoice dated 1/7/19, where he had just ordered the threshold. On 1/11/19 at 8: 08 pm and interview was conducted with the Director of nursing, and she stated that it is her expectation that the threshold needs to be take of when it was found, even if it is a temporary fix until the parts come in. 2. Resident rooms #129 and 306 During an observation on 01/08/19 at 3:27 PM, the floor under resident's bed had large amount of dried foods, liquids, heavy dust build up, trash on the floor, the bed frame had dried brown matter and liquids on the bed. During an interview on 1/8/19 at 3:43 PM, HKS staff who was cleaning the room stated it was an expectation to clean under resident's bed daily and deep clean weekly. He confirmed the floor had not been cleaned in some time. He also confirmed the condition of the bed frame. The room was clean the next day. 3. Observation on 1/7/19 at 1:17 PM, revealed the bed linen in room 111 was torn and had dark brown spots on it. The bed was not made and appeared to be soiled with what appeared to be dried food stains. Observation on 1/8/19 at 9:19 AM revealed the bed linen in room 111 was not changed, the linen was torn and had dark brown spots on it. During an interview Resident # 19 indicated the bed linens were not changed on regular basis. Resident also stated the staff had informed him that there were no clean linens available to be	F 584	deficient practice related to cleanliness of room, cleanliness of linen closets, missing thresholds. Housekeeping Supervisor conducted an audit of all resident rooms for deep cleanings completed as scheduled and as needed, audit completed on 01/28/2019. Four resident rooms will be auto scrubbed per week by facility floor tech with all furniture to be removed prior to auto scrub. The Facility Maintenance director completed an audit of facility resident rooms on 02/05/2019, and identified 4 rooms in need of threshold replacement or repair. Replacement and repairs were completed on 02/05/2019. The Director of Nursing, ADON and/or unit coordinators completed an audit completed on 02/06/2019 of current facility rooms to identify beds in need of linen change due to soiled/torn linens. Fourteen beds were identified and bed linens were changed on 02/06/2019. The housekeeping supervisor completed an audit completed on 02/06/2019 of linen closets to identify/validate linen closets were stocked and organized with clean linens. All linen closets were stocked and organized on 02/06/2019. Housekeeping Supervisor retrained current housekeepers on the 5 and 7 step cleaning procedures and how to conduct a morning walk through on 01/17/2019. Current housekeepers will conduct a walkthrough of their assigned rooms at least 3 times during their shift to ensure cleanliness of rooms. All rooms will be	

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F 584	Continued From page 9 provided to his geriatric bed During an interview on 1/8/19 at 10:41 AM, NA #1 indicated the resident's bed linens were changed daily after breakfast around 9 AM. NA #1 stated bigger size bed linens were unavailable when laundry delivers clean linen late. NA # 1 further stated the resident's bed was made with linens that were available. During an interview on 1/8/19 at 11:52 AM, the housekeeping manager indicated staff should not be using torn linen and should request the laundry staff for replacement. Housekeeping manager also stated the facility had extra big size bed linen in the storage and can be easily replaced if needed. The larger linens were in the linen closet. During an interview on 1/8/19 at 8:00 PM, Director of Nursing (DON) stated nursing staff need to request laundry department for bed linens when the appropriate size linens were unavailable. She stated it was unacceptable to use torn linen on resident's bed. 4a. An observation of the linen closet on the 100 hallways on 1/8/19 at 10:44 AM revealed closet was disorganized, and floor was unclean. The closet was stocked with bed linens, towels and comforters. The comforters were rolled and stuffed in shelves. 3 comforters were observed on the floor of the closet. 4b. An observation of the linen closet on the hallway between 100 and 200 on 1/8/19 10: 48 AM revealed closet was disorganized, and floor was unclean. The comforters were rolled and stuffed in shelves. 2 comforters were observed	F 584	placed on a deep cleaning scheduled developed by the Housekeeping District Manager, (to be completed quarterly and as needed). Housekeeping Manager or assistant will complete room inspections 5 times per week for 4 weeks, 4 times per week for 4 weeks, and then 2 times per week for 6 weeks to ensure that deep cleans are that are scheduled are completed. Housekeeping Supervisor or assistant will provide a copy of the deep cleaning to the nursing department so that residents are up and out of their rooms on the scheduled date. Housekeeping staff/laundry staff will check linen closets daily to restock and assure linen closets are well organized with clean linen. Maintenance Director or assistant will check 10 resident rooms for presence of thresholds between the bathroom and resident rooms 3 times per week for 2 weeks and then weekly for 8 weeks. Then beginning April 1, 2019 10 rooms will be checked monthly for 2 months. Housekeeping Manager or Assistant Manager will conduct room inspections of 12 resident rooms per day 5 days per week for 4 weeks, 4 times per week for 4 weeks and then 2 times per week for 6 weeks. District Manager or Housekeeping Supervisor will inspect at least 2 rooms per hall during each weekly visit. The District Manager or Housekeeping Supervisor will inspect at least 3 rooms per hall during each weekly	

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F 584	Continued From page 10 on the floor of the closet. During an interview, NA #1 indicated the laundry staff were responsible to maintain and keep the closet clean. During an observation and interview on 1/8/19 at 11:52 AM, the housekeeping manager stated it was not acceptable for the closet to be cluttered and for comforter to be on the floor. He indicated the laundry staff were responsible for keeping the linen closets clean. He stated it was his expectation for laundry staff to check the closets daily, clean the floors of the closet and arrange clean linen appropriately in the closet. During an interview on 1/8/19 at 11:55 AM, laundry staff #1 indicated he was aware of the clutter in the closet and the comforters on the floor.	F 584	visit. Housekeeping manager will report findings to monthly QAPI meeting and re-evaluate and adjust plan accordingly as identified by the QAPI committee to maintain compliance. Housekeeping supervisor will observe linen closets daily 5 times a week for 4 weeks then 3 times a week for 2 months to validate linen closets remain stocked with clean linens and organized. Housekeeping manager will review audits/monitors for patterns/trends and adjust plan accordingly as identified by the QAPI committee to maintain compliance. Maintenance Director or assistant will check 10 resident rooms for presence of thresholds between the bathroom and resident room 3 times per week for 2 weeks and then weekly for 8 weeks. Then beginning April 1, 2019 10 rooms will be checked monthly for 2 months. The Housekeeping Supervisor or assistant will review the plan during the monthly QAPI meeting and audits will continue at the discretion of the QAPI Committee to maintain compliance.	
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been	F 585		2/4/19

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F 585	Continued From page 11	F 585		

furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;

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F 585	Continued From page 12 (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency	F 585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 585	Continued From page 13 confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on staff interviews, resident and family interviews, and record review the facility failed to provide residents with the opportunity to file grievances anonymously and failed to provide a written grievance summary for 2 of 2 sampled residents (Residents #119 and #37) reviewed for grievances. Findings include: 1. Resident #119 was admitted on 08/18/18 with diagnoses in part, Diabetes Mellitus, cancer, and pressure ulcer. A record review of the most recent Minimum Data Set (MDS) dated 11/23/18 revealed Resident #119 was moderately cognitively impaired and was dependent on staff for all activity of daily living. Review of the facility's Grievance Log from October 2018 - January 2019 revealed two grievances were recorded for Resident #119. Record review revealed on 9/27/18 a grievance was submitted which alleged Resident #119 was sent to an appointment with dirty clothing and dirty hair. Review of this grievance revealed there was no written response or summary provided by the facility to the person who filed the grievance. Review of the next grievance for Resident #119	F 585	The Social service director (SSD) provided a written response on 01/18/2019 to resident #119□s responsible party regarding grievances that were voiced on 9/27/18 and 12/11/18. A copy of the written response was attached to the grievance reports. The SSD provided a written response on 01/18/2019 to Resident #37 regarding grievances documented on 9/4/18 and 12/28/18. A copy of the written response was attached to the grievance reports. The Administrator and SSD provided grievance forms at each nursing station and at the front lobby reception desk on 01/11/2019. A locked box was placed at each nurses station and front lobby reception desk on 01/11/2019 for anonymous grievance reports to be placed. The grievance officer and/or the Administrator will check the box daily, Monday-Friday, for anonymous grievances. Investigation of the grievance will be completed and kept in the facility grievance book. Current facility residents have the potential to be affected by the alleged deficient practice related to the facility not	

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F 585	Continued From page 14 that was dated 12/11/18 revealed several concerns regarding care were submitted. Review of this grievance revealed there was no written response or summary provided by the facility to the person who filed the grievance. During an interview with a family member of Resident #119 on 01/08/19 at 9:35 AM, the family member stated that she had made grievances regarding Resident #119 to the Director of Nursing and the Unit Manager when she had a concern, and they usually wrote the allegation on a sticky note. The family member stated that she had received any written response or summary from the facility for the grievances she had previously voiced. During interview on 1/9/19 at 3:14 PM, the Unit Manager indicated that any grievance was given to the Director of Nursing to be resolved. She was not aware of any grievances for Resident #119. During an interview on 1/10/19 at 5:50 PM, Administrator stated it was her expectation that resident complaints would be documented by staff on the Grievance/Complaint form and reported to the grievance officer within 24 hours. The grievance officer or the concern department should conduct a thorough investigation. Administrator also stated the concerns should be addressed with resident and/or representatives with appropriate documentation to support concerns and resolutions were satisfied and agreeable to the resident and/or resident's family with written documentation before 30 days. 2. Review of the most recent quarterly Minimum Data Set (MDS) dated 10/11/18 revealed Resident # 37 was readmitted to the facility on 5/2/18 with a diagnosis of spinal stenosis,	F 585	providing the opportunity for residents to anonymously submit a grievance and not providing a written summary to the person filing the grievance. The SSD completed an 100% audit on 01/10/2019, for current facility residents for the past 3 months, to validate that their grievances were followed up verbally and written. There were 54 residents that did not have a written response for their grievances. The Social Services Director completed written responses on 01/16/2019, provided them to the person who filed the grievance and filed a copy of the letter with the grievance in the grievance log. The Regional Director of Clinical Services completed an in service on 01/11/2019 educating Department Managers on Grievances/Complaints, Recording and Investigating, Grievance/Complaints, Filing. The Administrator and/or the Department managers completed in-service education on 01/11/2019 with Social Services staff, Activities staff, Dietary staff, Therapy staff, Nursing staff, Housekeeping staff, and Maintenance staff regarding, Completing, resolving, and following up on filed grievances within 5 days of receiving it. The education will be provided to newly hired staff members during orientation. When grievances are received, the grievance officer will log on the grievance log and the Administrator will assign the appropriate department manager to investigate and return grievance form along with the investigation results to the	

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F 585	Continued From page 15 neuralgia and neuritis and chronic pain. Resident #37 was cognitively intact and needed total assistance for all activities of daily living (ADLs). Review of the facility's Grievance Log from October 2018 - January 2019 revealed three (only 2 noted below) grievances were recorded for Resident #37. Review of the complaint/ grievance report dated 9/4/18, revealed Resident #37 voiced a concern related to clothes with bleach spots. A grievance was resolved on 9/4/18. There was no evidence of a written response or summary was provided to the resident. Review of the complaint/ grievance report dated 12/28/18, revealed Resident #37 voiced a concern related to resident' care. The report indicated the investigation was completed and staff was reeducated. The report indicated the grievance was resolved per the resident's satisfaction. The report did not indicate how the resolution was resolved. There was no evidence provided regarding what education, who educated the staff and which staff was educated. There was no evidence of a written response or summary was provided to the resident. During an interview on 1/8/19 at 8:40 AM, Resident #37 stated she filed two grievances one was related to ADL care and the other was laundry. Resident # 37 indicated she had not received a grievance summary. During an interview on 1/10/19 at 9:00 AM, Social Worker (SW) stated the written resolutions and a copy of the form were given to the resident / resident's family or representative 30 days after	F 585	grievance officer with 5 days of receiving the grievance. The grievance officer will provide a written summary to the person that filed the grievance within 5 days of receipt of the grievance and a copy of the written summary will be filed with the grievance form. The grievance officer and/or the SSD or Administrator will review the outstanding grievances during morning meeting 5 x a week. Grievance forms will be placed in easily accessible areas on each nurse□s station and at the front lobby reception desk, for residents and families to complete. Locked boxes are provided at each nurses□ station and at the front lobby reception desk for residents/family members/visitors to place grievance forms in anonymously. The grievance officer and/or the Administrator will check the box daily, Monday-Friday, for anonymous grievances. Investigation of the grievance will be completed and kept in the facility grievance book. The Administrator and/or Director of Nursing will audit the Grievance Log 5 times per week for 4 weeks, then weekly for 2 months to validate that the grievances have been properly logged, resolved and followed up on in writing within 5 days of receiving the grievance, unless the person submitting the grievance refuses written communication. The Administrator will review audits to identify patterns/trends and will adjust plan as necessary for continued compliance. The Administrator will review	

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F 585	Continued From page 16 the grievance was filed. SW stated he had no evidence that any response or summary was provided to the resident when a grievance was made by a resident. During an interview on 1/10/19 at 5:50 PM, Administrator stated it was her expectation that resident complaints would be documented by staff on the Grievance/Complaint form and reported to the grievance officer within 24 hours. The grievance officer or the concern department should conduct a thorough investigation. Administrator also stated the concerns should be addressed with resident and/or representatives with appropriate documentation to support concerns and resolutions were satisfied and agreeable to the resident and/or resident's family with written documentation before 30 days. 3. During an interview on 1/10/19 at 9:00AM, Social Worker (SW) indicated the grievance forms were available at the nursing station. SW stated the resident were required to ask for a complaint/ grievance form from staff if any concerns or grievances needed to be filed. SW was unable to specify how a resident was able to file a grievance anonymously. During an interview on 1/10/19 at 5:00 PM, Activity Director (AD) stated the grievance process was discussed in the resident council. AD stated the residents needed to ask staff for the grievance/ complaint forms and the staff would assist them to file a grievance. AD further stated the forms were available at the nursing station and were behind the counter at the front desk. AD was unable to state how a resident could file a grievance anonymously.	F 585	the plan during monthly QAPI and will continue to audit at the discretion of the QAPI committee.	

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F 585	Continued From page 17 During an interview on 1/10/19 at 5:30 PM, Administrator specified there was currently no way a resident could file a grievance anonymously and indicated the grievance/ compliant forms would be made available throughout the facility for residents who would like to obtain a form without having to request to obtain a form from staff, so they could then file an anonymous grievance.	F 585		
F 642 SS=E	Coordination/Certification of Assessment CFR(s): 483.20(h)-(j) §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1)Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not	F 642		2/8/19

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F 642	Continued From page 18 constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed coordinate and certify the completion of the Minimum Data Set (MDS) assessment on time for 6 of 35 sampled residents (Residents #19, #37, #62, #30, #29, and #138) reviewed for resident assessments. The findings included: 1. Resident #19 was admitted to the facility on 11/5/14 with multiple diagnoses, some of which included diabetes mellitus type II, morbid obesity, chronic obstructive pulmonary disease and major depression. A review of the annual minimum data set (MDS) assessment dated 10/4/18 indicated that Resident #19 was assessed as cognitively intact. Assessment indicated resident was extensive assistance with one-person assist for activities of daily living. The annual MDS of 10/4/18 was not signed by the Registered Nurse assessment coordinator to certify that it was complete until 11/1/18 and was submitted to the national data base at that time. During an interview with the MDS nurse on 1/11/19 at 10:00 AM, MDS nurse indicated she was aware the MDS assessments was signed late. During an interview on 1/11/19 at 11:36 AM, Administrator indicated due to no MDS coordinator available to complete the task, the assessments were not signed as completed in a	F 642	The date of RN signature for Residents #19, #37, #62, #30 and # 29 were signed outside of the appropriate time frame. The Clinical Director of Reimbursement provided education by 02/04/2019 for the MDS nurses, regarding completion and signing MDS assessments according to RAI guidelines. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Current facility residents have the potential to be affected by the same alleged deficient practice of MDS□s not being signed as completed timely. On 01/27/2019, the Clinical Director of Reimbursement completed an audit of current facility residents□ MDS. There were 53 MDS assessments that were identified that needed to be completed and signed. Facility completed 100% compliance with MDS completion and signature on 01/30/2019. The MDS nurses completed education by 02/04/2019 for the Social service directors, Activities director, and Dietary manager regarding time frame for completing MDS sections. MDS staff will notify Administrator or Regional Director of Operations of any MDS that is not completed within the 3-day closure window. MDS coordinator or assistant will monitor MDS in progress	

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F 642	Continued From page 19 timely manner. 2. Resident #37 was readmitted to the facility on 5/2/18 with diagnoses, that included spinal stenosis, multiple sclerosis, neuralgia and neuritis and chronic pain. A review of the quarterly minimum data set (MDS) assessment dated 10/11/18 indicated Resident #37 was assessed as cognitively intact. Assessment indicated was total dependence with two-person assistance for activities of daily living. The quarterly MDS of 10/11/18 was not signed by the Registered Nurse assessment coordinator as complete until 11/2/18 and was submitted to the national data base at that time. During an interview with the MDS nurse on 1/11/19 at 10:00 AM, MDS nurse indicated she was aware the MDS assessments were signed late. During an interview on 1/11/19 at 11:36 AM, Administrator indicated due to no MDS coordinator available to complete the task, the assessments were not signed as completed in a timely manner. 3. Resident #62 was admitted to the facility on 12/16/14 with diagnoses, that included dementia, altered mental status, major depression, anxiety disorder, palliative care. A review of the significant change minimum data set (MDS) assessment dated 12/18/18, revealed the MDS was not signed as completed by Registered Nurse assessment coordinator until 1/4/18 and was submitted to the national data	F 642	list on PCC and verbalize daily, 5 days per week, in morning standup meeting the assessments due for each day. The Administrator and/or the Director of Nursing will audit the MDS calendar 5 x week for 4 weeks then 3 times a week for 2 months, to identify completion dates for MDS□s and validate that MDS□s identified are completed and signed timely according to the RAI manual. The Administrator and/or the DON will review the plan during the monthly QAPI meeting and audits will continue at the discretion of the QAPI Committee to maintain compliance.	

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F 642	Continued From page 20	F 642		

base at that time.

During an interview with the MDS nurse on 1/11/19 at 10:00 AM, MDS nurse indicated she was aware the MDS assessments were signed late.

During an interview on 1/11/19 at 11:36 AM, Administrator indicated due to no MDS coordinator available to complete the task, the assessments were not signed as completed in a timely manner.

4. Resident #30 was readmitted to the facility on 3/3/17 with diagnoses that included atrial fibrillation, congestive heart failure, anxiety disorder and depression.

A review of the annual minimum data set (MDS) assessment dated 10/5/18 revealed Resident #30 was assessed as cognitively intact. Assessment indicated resident was extensive assistance with one-person assist for activities of daily living.

A review of the annual MDS of 10/5/18 revealed it was not signed as complete until 11/1/18 by Registered Nurse assessment coordinator and was submitted to the national data base at that time.

During an interview with the MDS nurse on 1/11/19 at 10:00 AM, MDS nurse indicated she was aware the MDS assessments were signed late.

During an interview on 1/11/19 at 11:36 AM, Administrator indicated due to no MDS coordinator available to complete the task, the assessments were not signed as completed in a timely manner.

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F 642	Continued From page 21	F 642		

5. Resident #29 was admitted to the facility on 11/28/11 with diagnoses that included coronary artery disease, multiple sclerosis, depression and dementia.

A review of the annual minimum data set (MDS) assessment dated 10/5/18 revealed resident was assessed as cognitively intact. Assessment indicated resident was extensive assistance with one-person assist for activities of daily living.

A review of the annual MDS of 10/5/18 revealed it was signed as complete on 11/1/18 by Registered Nurse assessment coordinator and was submitted to the national data base at that time.

During an interview with the MDS nurse on 1/11/19 at 10:00 AM, MDS nurse indicated she was aware the MDS assessments were signed late.

During an interview on 1/11/19 at 11:36 AM, Administrator indicated due to no MDS coordinator available to complete the task, the assessments were not signed as completed in a timely manner.

6. Resident #138 was admitted to the facility on 12/7/18 with multiple diagnoses, some of which included diabetes mellitus, urinary tract infection, debility cardiorespiratory condition, coronary artery disease, seizure disorder and depression.

A review of the 14 days admission minimum data set (MDS) assessment dated 12/19/18 revealed resident was assessed as cognitively intact. Assessment indicated resident was extensive assistance with one-person assist for activities of

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F 642	Continued From page 22 daily living. A review of the admission MDS of 12/19/18 revealed it was not signed as complete until 1/4/19 by Registered Nurse assessment coordinator and was submitted to the national data base at that time. During an interview with the MDS nurse on 1/11/19 at 10:00 AM, MDS nurse indicated she was aware the MDS assessments were signed late. During an interview on 1/11/19 at 11:36 AM, Administrator indicated due to no MDS coordinator available to complete the task, the assessments were not signed as completed in a timely manner.	F 642		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident	F 657		2/8/19

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F 657	Continued From page 23 and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff and family interviews the facility failed to involve residents and/or resident's representatives in the care planning process for 3 of 3 sampled residents reviewed for care plan participation (Residents #19, #152, #119). The findings included: 1. Resident #119 was admitted on 08/18/18 with diagnoses in part, Diabetes Mellitus, cancer, and pressure ulcer. A record review of the most recent Minimum Data Set (MDS) dated 11/23/18 revealed Resident #119 was moderately cognitively impaired and was dependent on staff for all activity of daily living. Review of the resident's care plan revealed it was reviewed by staff on 8/14/18and, but there was no indication that the resident's family participated in the care plan meetings or development of the resident's plan of care. During an interview with a family member of Resident #119 on 01/08/19 at 9:35 AM, the family member stated the facility had never previously invited the resident's family to a care plan	F 657	A care conference was held with resident #119'□s representative on 01/09/2019 and a multidisciplinary care conference form was completed. A care conference was held with resident # 19 on 01/02/2019, and a multidisciplinary care conference form was completed. A care conference was held with resident # 152 on 02/05/2019, and a multidisciplinary care conference form was completed. Current facility residents have the potential to be affected by the alleged deficient practice related to residents and/or resident□s representatives□ ability to participate in the care planning process. The Regional Director of Clinical Operation completed an 100% audit on 01/10/2019, for current facility residents, to validate that care plan conferences were held with residents and/or resident representative. There were 154 residents that did not have a Multidisciplinary Form	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345434	A. BUILDING _____ B. WING _____	C 01/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER LIVING CENTER	303 EAST CARVER STREET DURHAM, NC 27704

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F 657	Continued From page 24 meeting or to participate in developing the resident's plan of care. She stated she had been just been notified on 1/7/19 to come in for a care plan meeting on 1/09/19. During an interview on 1/10/19 at 9:00 AM, Social Worker (SW) indicated the care plan meeting invitation letter to residents and /or resident's family/ representative were sent out beginning of the month. SW stated no reminders were sent to the families as meeting day approached. SW was unsure if staff informed resident on the day of the care plan meeting. SW stated there was no documentation to prove the care plan meeting was conducted and who attended the meeting. SW also indicated there was no written information available to indicate the care plan meeting was completed for the resident. During an interview on 01/10/19 at 4:15 PM, MDS nurse (nurse # 6) was unable to confirm or deny if any care plan meeting was conducted. Nurse # 6 stated there was no documentation to prove if care plan meeting was conducted, who attended the meeting- including family and what was discussed. During an interview on 01/11/19 at 8:32 PM, The Administrator stated the expectation was that care plan meetings and notifications were per the state/ federal regulations. The Administrator stated the care plan should be reviewed and revised by the interdisciplinary team after each assessment, including comprehensive and quarterly assessments. She further stated residents and/or resident's representatives should be involved in the care plan meeting and make decision about their care. The Administrator further stated letters to the families should be sent out for care plan meeting and accommodate	F 657	completed, as evidence of a care plan conference being held or attendance of the resident and/or representative, following completion of a comprehensive and/or quarterly assessment. The Interdisciplinary Team (IDT), will complete care plan conferences that are outstanding by 02/08/2019, and document attendance by the resident and/or the resident representative using the Multidisciplinary Care Conference Form in the electronic medical record. The Administrator and Director of Nursing completed an in-service education on 01/11/2019, for Social Services, Activities, Dietary, Therapy, and MDS nurses regarding, Updating assessment calendars to include newly admitted residents and readmission of residents; sending letters to residents and/or resident representatives, inviting them to the care plan conferences; documenting in resident record to include invitation sent and resident and/or resident representative attendance. The education will be provided to newly hired IDT members during orientation. The MDS department will develop a calendar to include upcoming comprehensive and quarterly assessments to include new admissions and readmitted residents. The calendar will be given to the IDT to prepare for the care plan conferences. The MDS department will mail letters to residents and/or resident representative inviting them to the care plan conference. The IDT will complete the Multidisciplinary Care Conference Form in the electronic	

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F 657	Continued From page 25 the meeting based on families' convenience as much as possible. 2. Resident #19 was admitted to the facility on 11/5/14 with multiple diagnoses, some of which included diabetes mellitus type II, chronic obstructive pulmonary disease and major depression. Review of Resident #19's interdisciplinary team (IDT) notes dated 4/6/18, 6/29/18, 8/17/18, 9/14/18, and 10/19/18, revealed the team met to discuss the resident's behaviors. IDT notes dated 7/27/18 and 8/24/18 reveal the resident's falls were discussed during the team meeting. A review of the annual minimum data set (MDS) assessment dated 10/4/18 indicated that Resident #19 was assessed as cognitively intact. Assessment indicated resident was extensive assistance with one-person assist for activities of daily living. Review of the resident's care plan dated 11/27/18 revealed resident was care planned ADL's, behaviors, cognitive loss, urinary catheter, nutrition, falls and risk for pressure ulcers. The goals were measurable and reasonable and interventions appropriate. Review of the multi-disciplinary team conference assessment related to care plan meeting dated 1/2/19 indicated the assessment was "in progress". There were no assessments from February 2018 thru December 2018. During an interview on 1/8/19 at 11:35 AM, Resident # 19 indicated he was not invited to the care plan meeting since past 6 months and did not recall participating in developing his plan of	F 657	medical record when the care plan conferences are held and will include documentation regarding resident and/or resident representative attendance. The Administrator and/or DON will review calendar weekly and audit 5 residents weekly for 4 weeks, then 10 residents monthly for 2 months, that are scheduled for care plan review, to validate that care plan conference were held, Multidisciplinary Care Conference Forms were completed with documentation of attendance of the resident and/or resident representative. The Administrator will review audits to identify patterns/trends and will adjust plan as necessary for continued compliance. The Administrator will review the plan during monthly QAPI and will continue to audit at the discretion of the QAPI committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CARVER LIVING CENTER	303 EAST CARVER STREET DURHAM, NC 27704

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F 657	Continued From page 26	F 657		

care.
During an interview on 1/10/19 at 9:00 AM, Social Worker (SW) indicated the care plan meeting invitation letter to residents and /or resident's family/ representative were sent out beginning of the month. SW stated the letters were usually given to Resident # 19 and the resident would inform his family. SW stated no reminders were sent to the families as meeting day approached. SW was unsure if staff informed resident on the day of the care plan meeting. SW stated there was no documentation to prove the care plan meeting was conducted and who attended the meeting. SW also indicated there was no written information available to indicate the care plan meeting was completed for the resident.

During an interview on 01/10/19 at 4:15 PM, MDS nurse (nurse # 6) was unable to confirm or deny if any care plan meeting was conducted. Nurse # 6 stated there was no documentation to prove if care plan meeting was conducted, who attended the meeting- including family and what was discussed.

During an interview on 01/11/19 at 8:32 PM, The Administrator stated the expectation was that care plan meetings and notifications were per the state/ federal regulations. The Administrator stated the care plan should be reviewed and revised by the interdisciplinary team after each assessment, including comprehensive and quarterly assessments. She further stated residents and/or resident's representatives should be involved in the care plan meeting and make decision about their care. The Administrator further stated letters to the families should be sent out for care plan meeting and accommodate the meeting based on families' convenience as

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	345434	A. BUILDING _____ B. WING _____	C 01/11/2019

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F 657	Continued From page 27	F 657		

much as possible.

3. Resident #152 was admitted to the facility on 11/21/17 with diagnosis that included diabetes mellitus type II, encephalopathy, mild cognitive impairment, insomnia, rheumatoid arthritis, and muscle weakness.

Review of Resident # 152's interdisciplinary team (IDT) meeting note dated 3/21/18 revealed a care plan meeting was conducted with resident's family members. There were no IDT notes or multi-disciplinary team conference assessment after 3/21/18.

Review of the resident's care plan dated on 11/16/18 revealed resident was care planned ADL's, cognition loss, dental, nutrition, falls and risk for pressure ulcers. The goals were measurable and reasonable and interventions appropriate.

A review of the most recent minimum data set (MDS) assessment dated 12/12/18 indicated as quarterly assessment revealed Resident #152 was assessed as having moderately impaired cognition. Assessment indicated resident was independent for activities of daily living.

During an interview on 1/7/19 at 4:36 PM, Resident # 152 stated she was not informed about any care plan meeting, nor was anything discussed with her regarding her care plan by any staff.

During an interview on 1/10/19 at 9:00 AM, Social Worker (SW) indicated care plan meeting invitation letters were sent out the beginning of the month. SW stated no reminders were sent to

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F 657	Continued From page 28 the families as meeting day approached. SW was unsure if staff informed resident on the day of the care plan meeting. SW stated there was no documentation to prove the care plan meeting was conducted and who attended the meeting. SW also indicated there was no written information available to indicate the care plan meeting was completed for the resident. During an interview with MDS nurse on 01/10/19 at 4:15 PM, MDS nurse # 6 was unable to confirm or deny if any care plan meeting was conducted. Nurse # 6 stated there was no documentation to prove if care plan meeting was conducted, who attended the meeting- including family and what was discussed. During an interview on 01/11/19 at 8:32 PM, The Administrator stated the expectation was that care plan meetings and notifications were per the state/ federal regulations. The Administrator stated the care plan should be reviewed and revised by the interdisciplinary team after each assessment, including comprehensive and quarterly assessments. She further stated residents and/or resident's representatives should be involved in the care plan meeting and make decision about their care. The Administrator further stated letters to the families should be sent out for care plan meeting and accommodate the meeting based on families' convenience as much as possible.	F 657		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan	F 679		2/8/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 679	Continued From page 29 and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to provide an ongoing activity program that provided one on one activities as scheduled and met the individual interests and needs to enhance the quality of life for 3 of 3 sampled cognitively impaired residents reviewed for activities (Residents #97, #61 and #112). The findings included: 1. Resident #97 was admitted to the facility on 6/24/91. The diagnoses included cognition, communication deficits and dementia. The annual activities Minimum Data Set (MDS) dated 5/11/18 indicated 97's cognition was impaired and the MDS coded Resident #97 needed assistance with activities. Review of the last documented activity note dated 8/9/2018, revealed Resident #97 with a history of unspecified dementia with behavioral disturbance, anxiety disorder, major depressive disorder, heart failure, dysphagia, and epilepsy. resident vocalizes (screams, unclear sounds) but is unable to voice concerns. resident receives 1:1 from activity staff for increased socialization and stimulation. staff interventions include music, hand messages, nail care, reading, spending	F 679	The Activities Department completed on 100% audit on 01/11/2019 for current facility residents for the past 3 months who receive 1:1 visit (including the 3 sample residents #97, #61 and #112). Then, the Activities Director re-assessed current facility residents receiving 1:1 activities to determine the continued need for 1:1 activities and updated the 1:1 activity list. Activity Director updated activity care plans and assessments for those residents needing 1:1 activity service. Residents # 97, #61 and #112, that were found to be affected by the alleged deficient practice were included in the parameters of the 100% audit, reassessment of the 1:1 need, 1:1 list updated, care plans updated, and residents will continue to receive 1:1 activity. The activity staff will document on the residents activity participation record to accurately reflect the type of activity and residents participation. All other residents with cognitive impairment and who need 1:1 activity service have the potential to be affected	

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F 679	Continued From page 30 time outdoors, and showing pictures of family and friend. resident was able to track and make eye contact with staff and objects. activity staff will continue to encourage and engage resident in 1:1 program. Review of the care plan dated 12/4/18, identified the problem as resident was dependent on staff for meeting emotional, intellectual, physical and social needs related to cognitive deficits. The goal included the resident would receive 1:1 visits by activities staff and remain on 1:1 in room activity in room program. The approaches included all staff would converse with resident while providing care, resident enjoyed country music, television shows about cars and hunting, cars, sensory hand massages, maintain sensory, cognitive and social stimulation. The resident needed 1:1 beside in room visits and activities to include sensory hand massages, manicures, listening to music with activity staff, reading to resident, enjoys watching car, hunting shows and needs assistance/escort to activity functions out of room. Review of the facility's activity calendar for the dates of 1/7/19-1/11/19, revealed one to one room activities were scheduled daily at 12:00 PM. The calendar does not specify what one to one activity was scheduled for the day. During observations on 1/7/19 at 12:00 PM, Resident #97 was observed in his room being fed by staff, no specific activities being provided for resident. The television in the room was on but was not on a hunting or auto channel of resident's preference. During an observation on 1/8/19 12:00 PM, Resident #97 was observed in his room with no in room 1:1 activity being provided. Resident #97	F 679	by the same alleged deficient practice of failure to provide an ongoing activity program that provided one on one activities as scheduled and met the individual interests and needs to enhance the quality of life for cognitively impaired residents. The Activities Department completed on 100% audit on 01/11/2019 for current facility residents for the past 3 months who receive 1:1 visit (including the 3 sample residents #97, #61 and #112). Then, the Activities Director re-assessed current facility residents receiving 1:1 activities to determine the continued need for 1:1 activities and updated the 1:1 activity list. Activity Director updated activity care plans for those residents receiving 1:1 activity service. There were 15 residents identified that requires 1:1 activities. The activity director reviewed and updated the care plans and participation records for those 15 residents by 02/08/2019. The activity director completed activity assessments on the 15 identified residents by 02/08/2019. The Activities Director completed an in-service by 02/06/2019 with current activities staff, regarding completion of assessments, resident activity needs/calendar and documentation for residents that require one to one activities. The Activities Director will in-service new activity staff during orientation. The Activity director and/or activity staff will complete activity assessments upon admission, quarterly, annually and	

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	345434	A. BUILDING _____ B. WING _____	C 01/11/2019

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F 679	Continued From page 31 not being fed by staff at this time. Activities staff not present in room and the television in the room was on but was not on a hunting or auto channel of resident's preference. During an observation on 1/9/19 at 12:00 PM, Resident #97 was observed in his room with no in room 1:1 activities, and the television in the room was on, but not on a hunting or auto channel of resident's preference. Resident #97 was not being fed at this time, nor were there any activities staff present in the room. During an observation 1/10/19 at 12:00 PM, Resident #97 was observed in his room with no in room 1:1 activities, and the television in the room was on, but was not on a hunting or auto channel of resident's preference. Resident was not being fed at this time, nor were there any activities staff present in the room. Review of the resident's monthly activity participation record for October 2018, indicated the resident had refused one to one activity 4 times during the month and had 2 friendly visits for the month. Review of the resident's monthly activity participation record for December 2018, indicated the resident had friendly visits two times for the month. Record also indicated that the resident received only 1 one to one activity. The record did not specify the kind of activity the resident received. Record also indicated resident received one mail delivery for the 31 days in the month. During an interview on 1/10/19 at 4:06 PM, the Activities Director (AD) stated Resident #97 was receiving 1:1 activity and she was documenting	F 679	significant change and will update care plan and activity participation record as needed. The Administrator and/or The Activities Director will review the participation log 3 x a week for 4 weeks then weekly for 5 months, to validate documentation of visit occurrence, activity intervention, resident participation/refusal, and any additional preferences/comments. The Administrator and/or the activity director will observe/interview 5 residents weekly for 4 weeks then 10 residents monthly for 5 months to validate 1:1 activities are being provided according to the residents care plan. The Administrator and/or the activities director will review audits to identify patterns/trends and will adjust plan as necessary for continued compliance. The administrator will review the plan during monthly QAPI and will continue to audit at the discretion of the QAPI committee.	

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F 679	Continued From page 32	F 679		

on the participation record. The care plan was reviewed and did not indicate the frequency of the 1:1 visits. The AD further stated there was no formal activities assessment/preference done to identify the resident likes/dislikes/interest. The AD could not identify why the visits were so random and not documented for resident response or interaction. The AD was unable to confirm if Resident # 97 received any scheduled one to one activity at noon time as scheduled on the facility's activity calendar.

During an interview on 1/10/19 at 4:43, PM, the Administrator indicated the expectation would for the activities staff to do the activities assessment to include resident preferences, clarify on the care plan the frequency of the 1:1 of the visits and document quarterly resident interaction/involvement in the activities. The activity participation records should be utilized appropriately to accurately reflect the resident's activity participation.

2. Resident # 61 was admitted to the facility on 6/1/18 with diagnoses that included psychosis, cognitive communication deficit, blindness in right eye and low vision in left eye.

Review of the resident's admission activity evaluation form revealed, the form was incomplete and was not signed or dated.

Review of the resident's activity assessment dated 8/25/18 indicated status as" in progress". The assessment was blank and had no information related to resident's background information, personal preferences, daily preferences, activity preferences, participation preferences and participating setting.

A review of the most recent Minimum Data Set (MDS) assessment dated 10/23/18 marked as a quarterly assessment, revealed the resident's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345434	A. BUILDING _____ B. WING _____	C 01/11/2019

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F 679	Continued From page 33	F 679		

cognition was assessed as moderately impaired. Assessment indicated resident was total dependence with one-person assistance for activities of daily living (ADL).
Review of activity log for October 2018 revealed the resident participated in activities on the following dates: on 10/4/18 received cognition game as 1:1 activity, on 10/5/18 played trivia game, on 10/9/18 was reading, on 10/26/18 had a pet visit, and mail delivery was on 10/29/18.
Review of activity log for November 2018 revealed the resident participated in activities on the following dated: on 11/9/18 received a 1:1 activity, does not specify the kind of activity the resident received; On 11/15/18 and 11/20/18 resident had a pet visit him and on 11/12/18 the resident attended a social event.
Review of the updated care plan dated 12/3/18 revealed resident was care planned for activities. Goal was to maintain involvement in cognitive stimulation and social activities. Interventions included were to invite resident to scheduled activities, 1:1 bedside / in-room visits and activities if resident unable to attend out of room activities
Review of the resident's activity assessment dated 12/8/18 status as" in progress", revealed the assessments were blank and had no information related to resident's background information, personal preferences, daily preferences, activity preferences, participation preferences and participating setting.
Review of activity log for December 2018 revealed the resident had a pet visit him as a 1:1 activity on 12/17/18 and 12/27/18 and on 12/26/18 the resident was delivered mail.
Review of the facility's activity calendar for the dates of 1/7/19-1/11/19, revealed one to one room activities were scheduled daily at 12:00 PM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 679	Continued From page 34	F 679		

The calendar does not specify what one to one activity was scheduled for the day.
During an observation on 1/8/19 at 12:00 PM, Resident #61 was observed in his room sitting on his bed. Resident was not provided any specific one to one activity by staff. The television in resident's room was not on.
During an observation on 1/8/19 at 2:50 PM, Resident # 61 was observed in his room, sitting on his bed. Resident was not provided any specific one to one activity by staff. The television in resident's room was not on.
During an observation on 1/9/19 at 12:00 PM, Resident #61 was observed in his room. Resident was not provided any specific one to one activity by staff. The television in resident's room was not on.
During an interview on 1/9/19 at 2:00 PM, Nurse Aide (NA) #4 stated Resident #61 preferred to stay in his room and rarely left his room. NA #4 indicated the resident does not prefer to dine in the dining room. NA further stated resident rarely goes to activities and has not seen any staff do 1:1 activities with the resident.
During an interview on 1/9/19 at 3:13 PM, Nurse # 2 stated Resident # 61 does not like go activities. Nurse further stated she does not remember the resident going to group activities or activity staff conducting any one on one activities for the resident.
During an interview on 1/10/19 at 4: 49 PM, Activity Director (AD) was able to verbally state the resident's activity likes and dislikes. The AD indicated the resident prefers social events related to Veterans and would attend them. AD was unsure why resident did not receive adequate activities during the past 3 months reviewed. AD also stated it was important the assessments were completed on time. AD unable

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345434	A. BUILDING _____ B. WING _____	C 01/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER LIVING CENTER	303 EAST CARVER STREET DURHAM, NC 27704

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F 679	Continued From page 35	F 679		

to state why the resident did not receive any Noon visits by activity staff to provide 1 to 1 activities and why the visits were so random.
During an interview on 1/10/19 at 5:00, PM, the Administrator stated it was the expectation that the activity staff to include resident preferences in the activity assessment and the assessment was completed timely. Administrator further stated the care plan should clarify the frequency of the one on one activities and staff should document resident's involvement in the activities at least quarterly. Administrator stated the activity participation records should be utilized to accurately reflect the resident activity participate and should involve more one on one staff interactions.
3. Resident # 112 was admitted to the facility on 8/14/18 with diagnoses that included alcohol induced dementia, respiratory failure, chronic obstructive pulmonary disease, adult failure to thrive.
A review of the most recent Minimum Data Set (MDS) assessment dated 11/20/18 marked as a quarterly assessment, revealed the resident's cognition was assessed as moderately impaired. Assessment indicated resident was limited assist with one-person assistance for activities of daily living (ADL).
Review of the care plan dated 11/20/18 revealed Resident # 112 was care planned for activities. The goal was to maintain involvement in cognitive stimulation and social activities. Interventions included were to ensure the activities were compatible with resident's interests and preferences and to invite the resident to scheduled activities. Interventions indicated the resident preferred gospel radio stations and western television channel.
Review of activity note dated 11/20/18 read in part

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F 679	Continued From page 36	F 679		

"Resident #112 engages in independent leisure pursuits yet encouraged to participate in scheduled programs. Resident often declines invites to scheduled activities. Resident is seen by activity staff for 1:1 in room visits. Activity calendar posted in room".

Review of Resident #112's activity log for November 2018 revealed the resident received 1:1 activities on 11/9/18; 11/15/18; 11/20/18 all of which were pet visit and reality orientation 1:1 activity on 11/26/18.

Review of Resident #112's activity log for December 2018 revealed resident had 1:1 activities on 12/17/18 which was pet visit and friendly visit on 12/3/18 and 12/25/18.

Review of Resident #112's activity log for January 2019 activity log revealed the resident had not participated in any activities.

Review of the facility's activity calendar for the dates of 1/7/19-1/11/19, revealed one to one room activities were scheduled daily at 12:00 PM. The calendar does not specify what one to one activity was scheduled for the day.

During an observation on 1/8/19 at 12:00 PM, Resident #112 was observed in his room with no in room 1:1 activities, and the television in the room was not on. There was no music playing in his room and there was no activities staff present in the room.

During an observation on 1/9/19 at 12:10 PM, Resident #112 was observed in his room consuming his lunch. The television in the room was not on. There was no music playing in his room and no activities staff were present in his room.

During an observation on 1/10/19 at 12:00 PM, Resident #112 was observed in his room. The television in the room was not on. There was no music playing in his room and no activities staff

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	345434	A. BUILDING _____ B. WING _____	C 01/11/2019

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F 679	Continued From page 37 present in his room. During an interview on 1/10/19 at 4:06 PM, the Activities Director (AD) stated Resident #112 does not like to participate in group activities and does not like to come out of his room. The AD could not identify why the visits were so random. The AD was able to verbally report the resident's activity likes/preferences however, could not state why the activities were so limited. AD confirmed Resident # 112 was not provided one to one activity at Noon as scheduled each day on the facility's January activity calendar. During an interview on 1/10/19 at 5:00, PM, the Administrator stated it was the expectation that the activity staff to include resident preferences in the activity assessment and the assessment was completed timely. Administrator further stated staff should document resident's involvement in the activities at least quarterly. Administrator stated the activity participation records should be utilized to accurately reflect the resident activity participate.	F 679		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to monitor weights daily and notify	F 684	The licensed nurse notified the physician regarding the order for daily weights and	2/8/19

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F 684	Continued From page 38 the resident's physician of a weight gain of greater than three pounds as ordered 1 of 2 sampled residents reviewed for daily weight monitoring. (Resident #36) Findings include: Resident #36 was admitted to the facility on 07/20/18 with the diagnosis in part, Chronic Kidney Disease and Congestive Heart Failure (CHF). The most recent Minimum Data Set dated 10/10/18, revealed he had moderately impaired cognition and required limited assistance with activity of daily living (ADL). He had no shortness of breath during this assessment. Review of the care plan dated 8/9/2018, revealed Resident #36 had chronic kidney disease and the goal was no signs, symptoms or complications relate to fluid overload. Interventions that were in place were in part, to monitor, document and report as needed weight gain of over 2 lbs. (pounds) a day. Record review of the physician order dated 09/28/18 revealed to daily weigh one time a day for monitoring NOTIFY MD IF WEIGHT GAIN IS GREATER THAN 3 POUNDS. Record review of the physician order dated 10/06/18 revealed Furosemide (a diuretic) tablet 40 milligram give one (1) tablet by mouth one time a day for CHF. Review of the current weights on the electronic health record under the weight tab and the medication administration record (MAR) tab revealed no weight documented on 1/2/19, and a weight increase of 6.6 lbs. between 1/3/19 and	F 684	notification if weight gain greater than 3 lbs for Resident # 36. Resident #36 was weighed on 01/11/2019, with a weight of 132.8. The licensed nurse updated Resident #36 care plan to reflect current weight interventions related to weight monitoring. All other residents have the potential to be affected by the alleged deficient practice related to monitoring weights daily and notification of physician according to physician orders. The Director of Nursing and/or Assistant Director of Nursing completed an audit on 01/22/2019 of current facility residents with orders for daily and weekly weights. There were 29 residents identified with daily or weekly weight orders. The DON and/or ADON or unit coordinators reviewed the weights with the physician and new orders were obtained for 22 residents. The licensed nurses updated the residents care plan to reflect current weight monitoring interventions. The DON and/or ADON completed education by 01/23/2019, for the licensed nurses regarding following physician orders for obtaining weights as ordered and notification of physician according to the physician order. Daily/weekly weights will be obtained as ordered and documented on the MAR and the residents weight section of PCC. The licensed nurse will notify the physician according to the parameters given by the physician.	

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F 684	Continued From page 39 1/4/19. No weight was recorded on 1/5/19. Record review of Resident #36 nursing notes for 1/2/18 thru 1/5/19 revealed no documentation of his weight discrepancies or weight gain. During an interview on 01/11/19 at 10:25 AM the Assistant Director of Nursing indicated resident's that were weighed daily usually have a diagnosis of CHF. The unit managers handle the discrepancies, their own way. There should be a note regarding the weight discrepancy and a call to the physician documented in the resident's medical record. During an interview on 01/11/19 at 04:15 PM the Unit Manager indicated Resident #36's weight was not obtained staff on 1/2/19 and 1/5/19 and the resident experienced a 6.6 pound weight gain from 1/3/19 to 1/4/19. The Unit Manager stated that she was not aware of these issues until being informed by the surveyor on 01/11/19 and added the resident's physician was not notified, of the resident's 6.6 pound weight gain nor had the weight been logged for the days in question. During a telephone interview on 01/11/19 at 06:17 PM Nurse #12 indicated that that Resident #36 was weighed on the 3rd shift by an Aide. Then she documented the weight on the MAR and in the vital signs tab. If the weight was not documented she was not aware and didn't know why it didn't save. During an interview on 01/11/19 at 08:38 PM the Director of Nursing indicted the expectation was to have the weights documented and Resident #36's MD contacted as ordered when the resident experienced a weight gain greater than three or	F 684	The DON, ADON or unit coordinators will audit weights for residents with orders of daily/weekly weights, 5 times a week for 4 weeks, then 3 times a week for 2 months, to validate weights were obtained and documented as ordered and physician was notified as necessary according to the parameters given by the physician. The DON will review audits monthly to identify patterns/trends and will adjust plan as necessary. The plan will be reviewed during monthly QAPI meeting and audits will continue according to the discretion of the QAPI committee.	

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F 684	Continued From page 40 more pounds.	F 684		
F 744 SS=E	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a care plan which included interdisciplinary team , resident, resident family and/or family representative involvement in planning dementia care needs for 1 of 1 resident (Resident # 105) reviewed for dementia care. Finding included Resident #105 was admitted to the facility on 12/7/17 with diagnoses that included Alzheimer's dementia, delusion disorder, anxiety disorder, and insomnia. Review of the modified quarterly Minimum Data Set (MDS) assessment dated 11/16/18 indicated Resident #105 had severely impaired cognition. Resident # 105 was assessed with no behaviors and no rejection of care. Resident #105 was assessed as needing extensive assistance of 2 or more staff with bed mobility, transfers, toileting. Total dependence with one staff assistance with personal hygiene, and bathing. Resident was total dependent on 1 staff for assistance with locomotion on/off the unit, personal hygiene, with dressing and bathing. Resident was assessed as	F 744	The Social Service Director notified Resident # 105□s responsible party on 12/17/2018,inviting them to a care plan conference. A care conference was held with the IDT 01/18/2019. The Multidisciplinary care conference form was completed on 02/04/2019. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Current facility residents with dementia have the potential to be affected by the alleged deficient practice related to care plan development to include IDT, resident, resident family and/or family representative involvement in planning dementia care needs. Social Service Director completed an audit of care conferences completed in past 90 days. Audit of residents with dementia completed on 01/30/2019. Current residents including those with dementia were identified and letters were mailed to the resident representatives. Care plan conferences have occurred or has been scheduled with resident representatives.	2/8/19

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F 744	Continued From page 41 independent and needing set up assistance for eating. Review of the care plan dated 11/13/18 revealed Resident #105 was care planned for resistive to care and behavior disturbance, physical aggression, and Alzheimer's dementia. The Goals indicated Resident #105 will be in compliance with care, will not hurt self or other, and will be able to communicate daily basic needs. Interventions included - 1) resident enjoys music, staff to provide music during care to de-escalate behaviors, 2) allow extra time for 1:1 attention as needed, 3) Intervene before agitation escalates; Guide away from source of distress, 4) engage in simple, structured activities to avoid overly demanding tasks. Keep routine consistent and try to provide consistent care givers to decrease confusion. Further review revealed no care plan for dementia. Review of the interdisciplinary team (IDT) notes revealed on 10/19/18, 9/14/18, 8/24/18, 8/10/18, 7/27/18, 6/15/18 the team had met to discuss Resident #105's behavior. There were no others notes after 6/15/18. IDT notes did not indicate if Resident #105, resident family or family representative attended the meeting. Review of records also indicated lack of evidence that care plan meetings were conducted and were attended by resident family/ representative. Review of the Multidisciplinary care conference assessment dated 10/10/18 revealed the care plan meeting documentation was "in progress". The document was blank and did not contain any information related to IDT members who attended the meeting, what care areas were discussed in the meeting and what update was made in the	F 744	MDS staff will provide a list of residents that are due for care plan review to the SSD. The SSD or the MDS staff will send a letter of invitation to the resident representatives of residents with diagnosis of dementia for care plan conference scheduling. Care plan conference dates and times will be emailed to IDT as scheduled and announced the day of in daily (M-F) IDT stand up meeting. The IDT will complete the Multidisciplinary Care conference form in PCC and print the form to review with the resident representative and obtain signatures from all who attend. The printed form with signatures will be filed in the residents medical record. MDS or Social Work staff will maintain a Residents with Dementia Care Plan Monitoring Tool audit. Audit will be completed weekly for held care plan meetings and reviewed monthly for compliance. The MDS staff or SSD will review the audit monthly to identify patterns/trends and will adjust plan as necessary. The plan will be reviewed during monthly QAPI and the audits will continue at the discretion of the QAPI committee.	

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F 744	Continued From page 42	F 744		

care plan. The document did not contain information about resident or family members attending the meeting. The document was also not signed.

During an interview on 01/10/19 at 9:00 AM, Social Worker (SW) stated he could not confirm or deny if the care plan meeting was conducted. SW was also unable to state if he attended the care plan meeting. SW indicated care plan meeting letters were sent out at the beginning of the month. No reminders were sent to the families as meeting day approached. The SW stated there was no documentation to prove a care plan meeting was conducted for Resident #105 or who attended the meeting if there was a meeting. The SW also indicated there was no written evidence available to indicate the care plan meeting was completed for the resident.

During an interview with the MDS Nurse on 01/10/19 at 4:15 PM, she was unable to confirm or deny if any care plan meetings were conducted for Resident #105. MDS also stated that prior to December 2018, the care plan meeting notifications, letters and updates were done by the SW. The MDS Nurse stated there was no documentation to prove if a care plan meeting was conducted, who attended the meeting, including family and what was discussed. MDS nurse also stated the resident's family recently had some concern regarding resident's care and the facility staff addressed these concerns. MDS nurse indicated she was unsure if there was any care plan meeting with the family and if residents' goals and plan of care was discussed with the family.

During an interview on 01/11/19 at 8:32 PM, the

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F 744	Continued From page 43 Administrator stated the care plan should be reviewed and revised by the interdisciplinary team after each assessment, including comprehensive and quarterly assessments. She further stated residents and/or resident's representatives should be involved in the care plan meeting and make decision about their care. The Administrator further stated letters to the families should be sent out for care plan meetings and accommodate the meeting based on families' convenience as much as possible.	F 744		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to ensure 8 of 8 dietary staff members to wear beard restraints	F 812	Immediate implementation of beard guards was put into place upon survey visit. Administrator completed an	2/8/19

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F 812	Continued From page 44 during meal service. Review of the employee hygiene and sanitary practices policy dated October 2017 read in part " food and nutrition services employees will follow appropriate hygiene and sanitary procedure to prevent spread of foodborne illness. Hair nets or caps and / or beard restraints must be worn to keep hair from contacting exposed food, cleaning equipment, utensils and linen". 1. Observation of main dining room on 1/7/18 at 12:00 pm, revealed residents sitting in dining room waiting on food to be served. During this service, there were three male dietary aides, the dietary manager and the executive chief who were not wearing beard covers during dining service. On 1/8/19 at 11:40 am an observation was made of dietary manager who was not wearing beard cover while setting up meal trays. Observation on 1/8/9 at 4:55 pm reveals 2 dietary aides not wearing beard guards as well as the dietary manager and executive chief while serving dinner trays. During an interview with the executive chief on 1/9/19 at 2:04 pm he stated that all male should wear beard covers while cooking and serving the meals trays. He also stated that the policy stated that all hair and beards are to be covered when handling food. 2. Observation of the 100-dining hall on 1/8/19 from 5:30 to 5:50 PM, revealed two male dietary aide staff assisting at the steam table and not wearing beard guards. Both dietary aide #1 and dietary aide # 2 in an interview stated they had	F 812	in-service on 01/08/2019 for staff that were identified not wearing a beard guard on Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices which included hair net and beard restraint usage to keep hair from contacting exposed food, clean equipment, utensils and linens. 01/09/2019 with all dietary staff reviewing the policy on Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices which included hair net and beard restraint usage to keep hair from contacting exposed food, clean equipment, utensils and linens. Current facility residents have the potential to be affected by the alleged deficient practice related to dietary staff not wearing beard guards. On 01/09/2019 Dietary Manger completed an in service with all dietary staff reviewing the policy on Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices which included hair net and beard restraint usage to keep hair from contacting exposed food, clean equipment, utensils and linens. Dietary Manager or assistant will always keep beard guards available and accessible in the dietary department with all male staff members to wear beard guards. Beginning January 14, 2019, the Dietary Manager or assistant will monitor use of beard guard and hairnet use in the dietary	

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F 812	Continued From page 45 forgotten to wear the beard guard. Dietary aide # 3 and Dietary aide# 4 were observed transporting ice tea canisters to the dining hall on 1/8/19 at 5:45 PM. Both male dietary aides were not wearing a beard cover. Interview with dietary aide # 3 revealed he was a new employee and was not aware that a beard guard must be worn. During an interview, dietary aide # 4 indicated he did not think his facial hair was an issue. Dietary aide #4 further stated he had overlooked to wear his beard guard. During an interview on 01/10/19 at 03:17 PM, the dietary manager indicated the dietary staff were running late on 1/8/19 and in a haste had overlooked to wear their beard guards. He stated it was his expectation that all dietary staff should be wearing hair nets and beard guards during handling of resident's food.	F 812	department 5 times per week for 4 weeks and then beginning on February 11, 2019 monitoring will be completed 2 times per week for 2 weeks and then beginning February 25, 2019 monitoring will be completed weekly for 2 weeks. Then monitoring for beard guard and hairnet usage will be monthly times 3 months. The Dietary Manager or assistant will review the plan during the monthly QAPI meeting and monitoring will continue at the discretion of the QAPI committee to maintain compliance. This will be reviewed monthly and every 6 months unless substantial compliance is not maintained.	
F 867 SS=D	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, staff interviews, and record review the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following a recertification survey in February 2018 and subsequently recited in January 2019 on the	F 867	The Activities Department completed on 100% audit on 01/11/2019 for current facility residents for the past 3 months who receive 1:1 visit (including the 3 sample residents #97, #61 and #112). Then, the Activities Director re-assessed current facility residents receiving 1:1	2/8/19

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 46 current recertification and complaint survey. The recited deficiency was in provide activities to meet the interest/needs of each resident. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA Program. The findings included: The tag was cross referenced to: F 679 - Activities to meet the interest/needs of each resident Based on observations, staff interviews and record review, the facility failed to provide an ongoing activity program that provided one on one activities as scheduled and met the individual interests and needs to enhance the quality of life for 3 of 3 sampled cognitively impaired residents reviewed for activities (Residents #97, #61 and #112). During the previous survey on 2/09/18, the facility had failed to engage 6 of 6 residents with cognitive impairments in on-going activities on a dementia care unit (Residents #156, #95, #228, #227, #44 and #7) During an interview on 01/11/19 at 7:44 PM, the Administrator indicated the QAA committee 1) identifies areas of concern, 2) does a root cause analysis, 3) develops a plan, audits and monitors that plan and 4) discusses the outcome. The Administrator indicated QAA was a work in progress. Administrator also stated that the facility was focusing on certain areas but had not investigated the basic problems related to citations found in the current survey.	F 867	activities to determine the continued need for 1:1 activities and updated the 1:1 activity list. Activity Director updated activity care plans for those residents receiving 1:1 activity service. Residents # 97, #61 and #112, that were found to be affected by the alleged deficient practice were included in the parameters of the 100% audit, reassessment of the 1:1 need, 1:1 list updated, care plans updated, activity assessments completed and residents will continue to receive 1:1 activity. The activity staff will document on the residents activity participation record to accurately reflect the type of activity and residents participation. All other residents have the potential to be affected by the alleged deficient practice related to QAPI Committee failure to maintain implemented procedures and monitor the interventions that he committee put into place following recertification survey in February 2018, related to provision of activities to meet the interest/needs of each resident. All other residents with cognitive impairment and who need 1:1 activity service have the potential to be affected by the same alleged deficient practice of failure to provide an ongoing activity program that provided one on one activities as scheduled and met the individual interests and needs to enhance the quality of life for cognitively impaired residents. The Activities Department completed on 100% audit on 01/11/2019 for current facility residents for the past 3 months	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345434	A. BUILDING _____ B. WING _____	C 01/11/2019

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F 867	Continued From page 47	F 867		

who receive 1:1 visit (including the 3 sample residents #97, #61 and #112). Then, the Activities Director re-assessed current facility residents receiving 1:1 activities to determine the continued need for 1:1 activities and updated the 1:1 activity list. Activity Director updated activity care plans for those residents receiving 1:1 activity service. There were 15 residents identified that requires 1:1 activities. The activity director reviewed and updated the care plans and participation records for those 15 residents by 02/08/2019. The activity director completed activity assessments on the 15 identified residents by 02/08/2019.

The Activities Director completed an in-service on 02/04/2019 with current activities staff, regarding completion of assessments, resident activity needs/calendar and documentation for residents that require one to one activities.
The Activities Director will in-service new activity staff during orientation.
The Activity director and/or activity staff will complete activity assessments upon admission, quarterly, annually and significant change and will update care plan and activity participation record as needed.
The facility failed to follow the QAPI process for identifying, planning and implementing quality plans for improvement and did not continue ongoing monitoring to assure continued compliance in areas identified.
The Regional Director of Clinical Services

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F 867	Continued From page 48	F 867	provided education on 01/16/2019, to the Interdisciplinary team consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Social Service Director, Activities Director, Dietary Manager, Maintenance Director and Housekeeping supervisor, regarding the QAPI process to include how to identify, plan and implement a quality plan for improvement and ongoing monitoring to assure compliance. The Administrator is the QA coordinator at the facility and will hold monthly QAPI meetings to review and update plans that have been implemented to assure continued compliance. Members of the QAPI committee will consist of at least the Administrator, Director of Nursing, Medical Director, Social Service Director, Activities Director, Infection Control Nurse, Care plan coordinator, Dietary Manager, Maintenance Director and Housekeeping supervisor. A member of the direct care staff will also be invited to participate. Active Quality Plans will be reviewed weekly by the Administrator and the department managers to validate audits/monitors are being completed and adjust plans as necessary for continued compliance. The Administrator and/or The Activities Director will review the participation log 3 x a week for 4 weeks then weekly for 5 months, to validate documentation of visit occurrence, activity intervention, resident participation/refusal, and any additional preferences/comments.	

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F 867	Continued From page 49	F 867	The Administrator and/or the activity director will observe/interview 5 residents weekly for 4 weeks then 10 residents monthly for 5 months to validate 1:1 activities are being provided according to the residents care plan. The Administrator and/or the activities director will review audits to identify patterns/trends and will adjust plan as necessary for continued compliance. The administrator will review the plan during monthly QAPI and will continue to audit at the discretion of the QAPI committee	
F 924 SS=D	Corridors have Firmly Secured Handrails CFR(s): 483.90(i)(3) §483.90(i)(3) Equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure handrails in facility corridors were properly secured to the wall and free of sharp edges on 1 of 1 facility hallways where handrails were present (the corridor joining the 300 and 100 hallways). The findings included: Observation on 1/7/19 at 11:15 AM revealed the hand rails in the corridor joining the 300 and 100 hallways with no end caps. The end of the handrail had sharp edges that were not covered by the endcaps. Endcaps pieces were placed over the hand rails and were not affixed. Observation also revealed this was a heavily used corridor, used both by staff and residents. Residents who smoked were using this corridor	F 924	The Maintenance director and/or maintenance assistants repaired the handrail in the corridor joining the 300 and 100 hallways on 01/28/2019. Current facility residents have the potential risk of being affected by the broken and/or loose hand rails. The Maintenance director and maintenance assistance completed an audit by 01/30/2019, of all handrails within the facility, to identify loose or broken hand rails. Hand rails that were identified were repaired when identified. The Maintenance director completed education by 01/30/2019 for the maintenance assistance regarding	2/8/19

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F 924	Continued From page 50 to go to their smoking area in the 100 hallway. Observation of the handrails in the same corridor on 1/7/19 at 1:31 PM, revealed the hand rail on the right lower side was not properly attached to the wall, the screw between the handrail and wall was visible and the hand rail was loose and shaky to touch at that end. The ends of the hand rail had rough edges and was not covered by an end cap. Observation on 1/8/19 at 8:00 AM and at 1:33 PM revealed the top left corner and lower right-side handrails had end caps that were missing. The hand rails had sharp edges that were visible. The right lower side handrail was not properly fixed to the wall, the screws were loose and the handrail at that point shook when touched. Observation also revealed this was a busy corridor with staff and residents constantly using it to navigate between units. During an interview on 1/8/19 at 4:04 PM, the maintenance director indicated he was unaware that the end caps to the handrails were missing. The maintenance director indicated he did not receive any work order related to the handrails. He further indicated the corridor between 300 and 100 hallways was a heavy traffic area for food carts, wheelchair, staff and residents. He stated the end caps may have been broken due to a food cart hitting it. The maintenance director also stated the screws that affixed the handrails to the wall needed to be tightened so that the handrail was fixed firmly and did not shake at that point.	F 924	monitoring hand rails to assure all are properly secured and no sharp edges. The maintenance assistants will complete rounds throughout the facility at least 5 x/ week to identify broken or loose hand rails and repair when identified. The Maintenance director and/or maintenance assistants will monitor the TELS system daily for work orders to identify loose or broken hand rails, and will repair when identified. The Maintenance director will audit work orders regarding hand rails 3 x week for 4 weeks then weekly for 2 months, to validate hand rails were repaired. The Maintenance director will complete facility rounds 3 times a week for 4 weeks then weekly for 2 months to validate hand rails are properly secured and no sharp edges. The Maintenance director will review audits/rounds to identify patterns/trends and will adjust plans as necessary. The plan will be reviewed during monthly QAPI and the audits will continue at the discretion of the QAPI committee.	