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	345307	A. BUILDING _____ B. WING _____	C 03/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWWOOD NURSING CENTER	4414 WILKINSON BLVD GASTONIA, NC 28056

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E 000	Initial Comments An unnanounced recertifcation and follow-up survey was conducted 03/03/19 to 03/07/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# SBE711.	E 000		
F 000	INITIAL COMMENTS Due to the system being down the statement of deficiencies could not be posted until 3/22/19 (the 11th day following the survey exit date).	F 000		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and pharmacist interviews the facility failed to accurately code the Minimum Data Set (MDS) to reflect the skin condition (Resident #19), fall occurrence (Resident #2) and diagnoses (Resident #33, #7 and #41) for 5 of 5 sampled residents whose MDS assessments were reviewed for accuracy. Findings included: 1. Resident #19 was admitted to the facility on 05/09/14. A physician's order for Resident #19 dated 10/18/18 indicated staff were to change scheduled Risperdal (antipsychotic medication) to every bedtime as needed and if no use in 14 days then the medication was to be discontinued.	F 641	1. The corrective action for the residents affected by the alleged deficient practice were accomplished for the following residents Res #2, #33, # 7, # 41 and # 19 which was modified on 3/5/19 to reflect res #19 did not receive the antipsychotic medication during the look back period which is 7 days. 2. All residents have the potential to be affected by the alleged deficient practice. The MDS Nurse have reviewed the pharmacist notes, incident/accidents logs and new residents admission diagnosis as of 3/8/19 to ensure the most recent MDS information accurately reflects each residents status. The MDS assessments for ten (10) residents were audited 3/11/19 -3/15/19 by the Administrator and	4/1/19

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

Electronically Signed | 04/01/2019

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F 641	Continued From page 1 A review of the monthly physician's orders from 11/01/18 to 11/30/18 for Resident #19 indicated Risperdal 0.5 milligrams (mg) 1 tablet orally at bedtime as needed and if not used in 14 days was discontinued on 11/02/2018. A review of a pharmacist monthly visit note dated 12/05/18 indicated Risperdal was discontinued for Resident #19 on 11/02/18. A review of Resident #19's quarterly Minimum Data Set (MDS) assessment dated 01/08/19 indicated Resident #19 had been coded under Section N Medication Received as receiving an antipsychotic medication times 7 days. On 03/04/19 at 10:34 AM an interview was conducted with the pharmacist who stated Resident #19's Risperdal antipsychotic medication was discontinued on 11/02/18. On 03/04/19 at 2:01 PM an interview was conducted with the MDS Coordinator who stated she began working at the facility on 01/24/19 and had not coded Resident #19's quarterly MDS assessment dated 01/08/19. The MDS Coordinator verified that Resident #19 had an order to discontinue Risperdal on 11/2/18. The MDS Coordinator verified that the pharmacist indicated in the pharmacist review note of 12/05/18 that Resident #19's Risperdal antipsychotic medication had been discontinued on 11/2/18. The MDS Coordinator verified during the look back period of 01/02/19 to 01/08/19 that Resident #19 had not received an antipsychotic medication times 7 days. The MDS Coordinator stated Resident #19 should not have been coded on the quarterly MDS assessment dated 01/08/19 under Section N Medications Received as	F 641	Treatment/Unit Nurse for accuracy. 3. Education was provided to the MDS nurse on 3/19/19 by DHSR in Marion NC which consisted of accuracy of assessments regarding coding, timely submission, initial assessments, quarterly assessments and annually assessments to help to ensure that the deficient practice does not recur. 4.Monitoring to ensure compliance regarding accuracy of assessments: The Administrator and Acting DON will continue to audit three random section of 5 residents MDS per week x 4 weeks then 2 per week x□s 4 weeks starting 3/11`/2019. Data will be summarized and presented to the facility Quality Assurance Performance Improvement Committee meeting monthly x 2 months by the Administrator and or Acting DON. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised to ensure continued compliance. The Administrator and or Acting Director of Nursing are responsible for implementing and maintaining the acceptable plan of correction. Corrective action will be completed on or before 4/1/2019.	

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receiving an antipsychotic medication times 7 days. The MDS Coordinator stated she would need to submit a modification to the quarterly MDS assessment dated 01/8/19 to indicate Resident #19 had not received an antipsychotic medication during the 7 day look back period.

On 03/04/19 at 2:30 PM an interview was conducted with the interim Director of Nursing (DON) who stated her expectation was that the quarterly MDS assessment dated 01/8/19 would have been accurately coded to reflect Resident #19 had not received an antipsychotic medication during the look back period from 01/02/19 to 01/08/19. The DON stated her expectation was that the quarterly MDS assessment dated 01/08/19 would be modified and submitted to accurately reflect Resident #19 did not receive antipsychotic medication during the 7 day look back period.

On 03/04/19 at 2:46 PM an interview was conducted with the administrator who stated it was her expectation that quarterly MDS assessment dated 01/08/19 would have been accurately coded to reflect Resident #19 had not received antipsychotic medication during the 7 day look back period. The Administrator stated her expectation was the quarterly MDS assessment 01/08/19 would be modified and submitted to accurately reflect Resident #19 had not received antipsychotic medication during the 7 day look back period.

2. Resident #29 was admitted to the facility on 1/10/17 with a diagnosis that included dementia with behavioral disturbance, Heart failure, Major depressive disorder, generalized anxiety disorder, Alzhimers disease, chronic pain, lack of

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coordination, and history of falling. The most recent Minimum Data Set (MDS) assessment dated 1/9/19 indicated Resident #29 was coded as not having a fall for since admission or during the previous assessment.

Review of the facilities incident/Accident log for the month of November 2018 revealed Resident #29 had 2 falls. A fall on 11/2/18 and a fall on 11/19/18.

Review of Resident #29's nursing note dated 11/2/18 stated the nurse was notified by a nursing assistant (NA) that the resident had fallen out of bed. The note continued that the nurse entered Resident #29's room and Resident #29 was found face down with her head bleeding. A laceration was noted to the right side of Resident #29's head. 911 was contacted and Resident #29 was transported by emergency medical services to the hospital.

Review of a nursing note dated 11/19/18 stated resident #29 had an assisted fall with no injury from wheelchair by the NA. The steps taken to prevent further recurrences included a physical therapy referral and re-enforce education on transfers to staff.

Interview with the MDS coordinator on 3/7/19 at 9:11AM revealed she became aware of residents falls during morning meetings. She further revealed that she was occasionally made aware of falls verbally by nursing staff. Following the review of Resident #29's nursing note dated 11/2/18 and 11/19/18 the MDS coordinator stated the Resident #10 had 2 falls should have been coded on the MDS dated 1/9/19 and were not.

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Interview with Nurse Consultant on 3/07/19 at 1:33 PM revealed that it is her expectation for the falls to be coded correctly on the MDS.

Interview with the Administrator on 3/7/19 at 4:28 PM revealed it was her expectation that MDS assessments be accurately coded for falls.

3. Resident #33 was admitted to the facility on 01/14/19 with diagnoses which included dementia and Parkinson's disease.

A review of Resident #33's admission Minimum Data Set (MDS) assessment, dated 01/22/19, indicated Resident #33 was not coded under Section I: Active Diagnoses as having dementia and Parkinson's disease.

During an interview on 03/06/19 at 9:29 AM, the MDS Coordinator indicated that the dementia and Parkinson's disease diagnoses were not coded and that she did not start working as the MDS Coordinator until 02/04/19. She further indicated the previous MDS Coordinator, who was no longer employed, worked on the MDS. She stated the diagnoses should have been coded because the MDS Coordinator's responsibility was to review the discharge summary or Admission FL2 form to code diagnoses.

During an interview on 03/06/19 at 10:16 AM, the Administrator indicated that the dementia and Parkinson's disease diagnoses were not coded on the MDS because the previous Director of Nursing (DON) and MDS Coordinator quit. She further indicated her expectation was the diagnoses should have been coded on the MDS.

During an interview on 03/07/19 at 10:30 AM, the

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F 641	Continued From page 5	F 641		

Corporate Nurse Consultant indicated her expectation was the dementia and Parkinson's disease diagnoses should have been coded on the MDS.

4. Resident #41 was admitted to the facility on 01/30/19 with diagnoses which included respiratory failure and Alzheimer's disease.

A review of Resident #41's admission MDS assessment, dated 02/05/19, indicated Resident #41 was not coded under Section I: Active Diagnoses as having respiratory failure and Alzheimer's disease.

During an interview on 03/06/19 at 9:29 AM, the MDS Coordinator indicated that the respiratory failure and Alzheimer's disease diagnoses were not coded. She further indicated that she did sign the admission MDS but was not sure why it the diagnoses were not coded because the previous MDS Coordinator also worked on the MDS before she quit. She stated the diagnoses should have been coded because the MDS Coordinator's responsibility was to review the discharge summary or Admission FL2 form to code diagnoses.

During an interview on 03/06/19 at 10:16 AM, the Administrator indicated that the respiratory failure and Alzheimer's disease diagnoses were not coded on the MDS because the previous Director of Nursing (DON) and MDS Coordinator quit. She further indicated her expectation was the diagnoses should have been coded on the MDS.

During an interview on 03/07/19 at 10:30 AM, the Corporate Nurse Consultant indicated her

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F 641	Continued From page 6 expectation was the respiratory failure and Alzheimer's disease diagnoses should have been coded on the MDS. 5. Resident #7 was admitted to the facility on 9/23/16 with diagnoses that included: atrial fibrillation, and gastroesophageal reflux disease (GERD). A review of Resident #7's medical record revealed a physician's order dated 11/7/18 for Xarelto 5 mg to be given twice a day for atrial fibrillation. Another physician's order dated 11/1/18 for Ranitidine 150 mg to be given at bedtime for GERD. A review of the quarterly Minimum Data Set (MDS) dated 12/7/18 revealed Resident #7 was cognitively intact. Further review of the MDS revealed atrial fibrillation and GERD were not coded as active diagnoses. An interview conducted on 3/6/19 at 3:25 PM with the MDS Coordinator revealed she was new to the position and the 12/7/18 quarterly MDS was coded by the prior MDS Coordinator. She further agreed the atrial fibrillation and GERD diagnoses were not coded accurately and stated she would submit a modification. An interview conducted on 3/6/19 at 3:30 PM with the Corporate Nurse Consultant revealed she expected that MDS assessments would be accurately coded by the MDS Coordinator.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans	F 656		4/1/19

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F 656	Continued From page 7 §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this	F 656		

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F 656	Continued From page 8 section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop interventions for care plans for 1 of 1 resident reviewed for rehabilitation and restorative services (Resident #33). Findings included: Resident #33 was admitted to the facility on 01/14/19 with multiple diagnoses that included dementia and Parkinson's disease. A review of the annual Minimum Data Set (MDS), dated 01/22/19, indicated Resident #33 had severe cognitive impairment and required limited assistance with 1-person physical assistance for bed mobility, transfers, and dressing. The MDS revealed Resident #33 was coded as being incontinent of bowel and bladder and was at risk for developing pressure ulcers. A review of a care plan, dated 01/29/19, revealed Resident #33 was incontinent of bowel, at risk for decline in skin integrity, dignity, and at risk for urinary tract infections related to bladder incontinence and cognitive deficits. The target goal of the care plan, dated 02/15/19, revealed the facility would minimize the resident's loss of dignity and risk of infection through next review period. Further review of the care plan revealed there were no interventions listed to carry out the care plan goal. A review of a care plan, dated of 01/29/19, revealed Resident #33 had a diagnosis of Parkinson's and was at risk for aspiration of food,	F 656	1. The Corrective action for the residents affected by the alleged deficient practice will be accomplished for the following resident #33 in order to carry out the care plan goals, effective interventions were added to resident□s care plan on 03/06/19. 2. In order to identify other residents that have the potential to be affected by the same deficient practice. The MDS and or Designee have audited the residents care plans in the daily Clinical meeting to ensure interventions are in place to carry out the care plan goals of the residents. 3. Education was provide on 3/28/2019 to the MDS Nurse, Social Worker/ Activities, Dietary supervisor, and the Therapy Director by the Administrator regarding Developing/Implementing Comprehensive Care Plan and how to put appropriate Interventions in place for care plans that trigger to assist with ensuring the deficient practice does not recur. 4. Monitoring to ensure compliance regarding Develop/Implement Comprehensive Care Plan: The Administrator and or Interdisciplinary team member will audit five resident care plans per week x□s 4 weeks then 2 per week x□s 4 weeks in order to ensure compliance. Data will be summarized and presented to	

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F 656	Continued From page 9 decreased mobility, bladder and bowel dysfunction, skin breakdown, depression, and general debilitation. The target goal of the care plan, dated 02/15/19, revealed the resident would be kept as active, mobile, and independent as possible; would be free from signs or symptoms of aspiration; would be free from skin breakdown; would be free from constipation; would have no decline in bowel or bladder function; and would not exhibit any signs or symptoms of depression through next review period. Further review of the care plan revealed there were no interventions listed to carry out the care plan goal. During an interview on 03/06/19 at 9:29 AM, the MDS Coordinator indicated she did not start working as the MDS Coordinator until 02/04/19. She further indicated she was responsible for updating Resident #33's care plan. She stated she did not have an answer as to why the interventions were not added to the care plans. During an interview on 03/07/19 at 10:30 AM, the Corporate Nurse Consultant indicated her expectation was for care plans to be fully completed for each resident. During an interview on 03/07/19 at 01:15 PM, the Administrator indicated her expectation was for care plans to completed for each resident. She further indicated the care plan was not completed because the previous Director of Nursing and MDS Coordinator both quit at the same time.	F 656	the facility Quality Assurance Performance Improvement Committee meeting monthly x 2 months by the Administrator and or Acting DON. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised to ensure continued compliance. The Administrator and or Acting Director of Nursing are responsible for implementing and maintaining the acceptable plan of correction. Corrective action will be completed on or before 4/1/2019.	
F 657 SS=E	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	F 657		4/1/19

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F 657	Continued From page 10 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 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 observations, record review and staff interviews, the facility failed to review and/or revise care plans to reflect the individual care needs for: 2 of 2 residents reviewed for accidents (Resident #15 and #28), 1 of 5 residents reviewed for activities of daily living (Resident #11) and 1 of 2 residents reviewed for pressure ulcers (Resident #10). Findings Included: 1. Resident #15 was admitted to the facility on	F 657	The corrective action for the residents affected by the alleged deficient practice will be accomplished for the following residents # 15 and # 28 reviewed for accidents Res# 11 is Res reviewed activities of daily living, and Res # 10 for pressure ulcers in which up dated care plans were completed on 3/19/19. 2. In order to identify residents that have the potential to be affected by the same deficient practice. The MDS and Social	

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F 657	Continued From page 11 09/28/17 with multiple diagnoses that included Alzheimer's disease, end-stage renal disease, diabetes, and chronic pain. Review of the annual Minimum Data Set (MDS) dated 01/01/19 indicated Resident #15 had moderate impairment in cognition and required extensive to total staff assistance with all activities of living except for eating. Side rails were not coded as being used during the MDS assessment period. Review of the care plans for Resident #15, with a revised date of 01/23/19, revealed no care area, goal or interventions for the use of side rails. Observations conducted on 03/03/19 at 11:55 AM, 03/04/19 at 9:06 AM and 03/06/19 at 6:02 AM revealed Resident #15 was lying in bed in a supine (lying face upward) position with half side rails located at the head of the bed and in the upright position on both the right and left side. During these observations, Resident #15 made no attempt to use the side rails to move or reposition himself. During an interview on 03/07/19 at 9:51 AM Nurse Aide (NA) #2 revealed Resident #15 required total staff assistance for bed mobility and transfers. NA #2 confirmed both the right and left side rails were always raised whenever Resident #15 was lying in bed. During an interview on 03/07/19 at 11:17 AM, the MDS Coordinator explained she started her employment with the facility on 01/24/19 and transitioned to the MDS position on 02/04/19. She confirmed both the right and left side rails were used whenever Resident #15 was lying in	F 657	Worker have audited resident care plans as of 3/15/19 in order to ensure that care plans are revised and updated quarterly and as needed to accurately reflect the resident□s condition. 3. The Administrator has in-serviced the MDS, Social Worker/Activities, Therapy Director and Dietary supervisor regarding the regulation components of Comprehensive Care Plans on 3/28/19 to help to ensure the deficient practice does not recur. 4. Monitoring to ensure compliance regarding Care Plan Timing and Revision: The Administrator and or Acting DON will continue to audit starting 3/18/19 5 random care plans per week x□s' 4 weeks then 3 per week x□s 4 weeks in order to ensure that care plans are updated accurately with goals and interventions in place. Physician orders for antibiotics will be audited 2 x's a week x's 3 weeks then 1x per week x's 2 weeks begining 3/15/19 in order to sustain compliance. Data will be summarized and presented to the facility Quality Assurance Performance Improvement Committee meeting monthly x 3 months by the Administrator and or Acting DON. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised to ensure continued compliance. The Administrator and or Acting Director of Nursing are responsible	

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F 657	Continued From page 12 bed. The MDS Coordinator explained she wouldn't necessarily create a separate care plan for side rail use but would add it as a goal and/or intervention on another care plan such as falls or activities of daily living. She added care plans were reviewed/revised by the interdisciplinary team quarterly and Resident #15's care plans should have been updated to reflect side rail use when the quarterly MDS dated 01/01/19 was completed. During an interview on 03/07/19 at 11:55 AM the Corporate Nurse Consultant (CNC) stated it was her expectation for care plans to be updated quarterly and accurately reflect the resident's care needs. During an interview on 03/07/19 at 1:52 PM the Administrator stated it was her expectation care plans were revised and updated as needed to accurately reflect the resident's condition. 2. Resident #28 was admitted to the facility on 07/11/18 with multiple diagnoses that included left-sided hemiplegia (paralysis on one side of the body), dementia, and muscle weakness. Review of the quarterly Minimum Data Set (MDS) dated 01/22/19 indicated Resident #28 had moderate impairment in cognition and required total staff assistance with all activities of living except for eating. Side rails were not coded as being used during the MDS assessment period. Review of the care plans for Resident #28, with a revised date of 10/30/18, revealed no care area, goal or interventions for the use of side rails. An observation conducted on 03/04/19 at 3:02	F 657	for implementing and maintaining the acceptable plan of correction. Corrective action will be completed on or before 4/1/2019.	

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PM revealed Resident #28 lying in a supine position (lying face upward) up against the right side of the bed close to the wall. The right side of Resident #28's bed was pushed up against the wall with a fall mat positioned lengthwise between the bed and wall. A side rail on the left side located at the head of the bed was noted to be in the upright position. Additional observations conducted on 03/05/19 at 3:06 PM and 03/06/19 at 6:01 AM revealed the half side rail was in the upright position while Resident #28 was lying in bed. During these observations, Resident #28 made no attempt to use the side rail to move or reposition himself.

During an interview on 03/07/19 at 9:51 AM Nurse Aide (NA) #2 revealed Resident #28 required total staff assistance and stayed in the same position when lying in bed until turned and repositioned by staff. She explained they used to place fall mats on the floor on each side of Resident's #28's bed but since putting the bed up against the wall, they now placed the fall mat in between the wall and bed to protect his knees since he tended to lie close to the wall. NA #2 confirmed the left side rail was always raised whenever Resident #28 was lying in bed.

During an interview on 03/07/19 at 11:17 AM, the MDS Coordinator explained she started her employment with the facility on 01/24/19 and transitioned to the MDS position on 02/04/19. She confirmed a side rail was used whenever Resident #28 was lying in bed. The MDS Coordinator explained she wouldn't necessarily create a separate care plan for side rail use but would add it as a goal and/or intervention on another care plan such as falls or activities of daily living. She was unaware the fall care plan

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included the intervention that fall mats were to be placed on the floor on each side of Resident #28's bed. The MDS Coordinator acknowledged Resident #28's fall care plan should have been updated to reflect the revised intervention in addition to the use of the left side rail. She added care plans were reviewed/revised by the interdisciplinary team quarterly and Resident #28's care plans should have been revised when the quarterly MDS dated 01/24/19 was completed.

During an interview on 03/07/19 at 11:55 AM the Corporate Nurse Consultant (CNC) stated it was her expectation for care plans to be updated quarterly and accurately reflect the resident's care needs.

During an interview on 03/07/19 at 1:52 PM the Administrator stated it was her expectation care plans were revised and updated as needed to accurately reflect the resident's condition.

3. Resident #11 was admitted to the facility on 06/06/18 with multiple diagnoses that included wedge compression fracture of the third lumbar vertebra, muscle weakness and low back pain.

Review of the quarterly Minimum Data Set (MDS) dated 12/17/18 indicated Resident #11 had intact cognition and required extensive assistance of 1 to 2 staff members for walking, locomotion and transfers. Further review of the MDS revealed Resident #11 was not steady with his balance during transitions and walking.

Review of the Activities of Daily Living (ADL) care plan, last revised on 09/25/18, included the intervention added on 07/12/18 the restorative

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nursing program would provide Resident #11 with therapy services for ambulation, standing and strengthening.

During an on interview 03/07/19 at 10:50 AM the Restorative Aide (RA) confirmed she provided Resident #15 with restorative therapy for ambulation and balance exercises. She added his last day of restorative therapy was 12/17/18.

During an interview on 03/07/19 at 11:17 AM, the MDS Coordinator explained she started her employment with the facility on 01/24/19 and transitioned to the MDS position on 02/04/19. The MDS Coordinator reviewed Resident #11's ADL care plan and acknowledged the care plan included an active intervention that he received restorative therapy for ambulation and balance. She added care plans were reviewed/revised by the interdisciplinary team quarterly and Resident #11's care plan should have been updated to reflect he no longer received restorative services when the quarterly MDS dated 12/17/18 was completed.

During an interview on 03/07/19 at 11:55 AM the Corporate Nurse Consultant (CNC) stated it was her expectation for care plans to be updated quarterly and accurately reflect the resident's care needs.

During an interview on 03/07/19 at 1:52 PM the Administrator stated it was her expectation care plans were revised and updated as needed to accurately reflect the resident's condition.

4. Resident #10 was admitted to the facility on 08/28/2018 with a diagnosis that included Type 2 Diabetes mellitus with unspecified complications,

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Hypertensive chronic kidney disease with stage I through stage IV, and a stage 4 pressure wound to the coccyx. The most recent Minimum Dated Set (MDS) assessment dated 12/20/2018 revealed Resident #10 was cognitively severely impaired, required extensive assistance for turning and repositioning and had pressure ulcer Stage I or greater.

Review of Resident #10's care plan initiated 9/11/18 revealed a "focus" of resident had potential for pressure ulcer development related to immobility, incontinence and potential for alteration in hydration/nutrition related to medial ankle stage IV identified on 11/15/18. Right hip stage IV identified on 11/20/18, right heel unstageable identified on 10/29/18, coccyx stage IV identified on 10/22/18 and left hip that was unstageable identified on 2/5/19. The goal stated Resident #10's current pressure ulcers and non-pressure areas would show signs of healing and remain free from infections. The interventions included monitor dressing to ensure it is intact and adhering, report lose dressing to treatment nurse, and report any signs of infection and monitor lab work. The interventions were not updated to include heavy growth of pseudomonas Aeruginosa or osteomyelitis with the administration of an antibiotic.

Review of Resident #10's wound culture obtained 2/22/19 reveled heavy growth of pseudomonas aeruginosa.

Review of Resident #10's wound biopsy of the coccyx obtained 2/22/19 revealed acute Osteomyelitis.

Review of physician order dated 2/26/19 stated

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F 657	Continued From page 17 cipro 500 milligrams (mg) for 6 weeks and intramuscularly (IM) gentamicin 0.1 percent for 6 weeks per pharmacy order. An interview with the MDS coordinator on 03/06/19 at 11:29 AM, revealed she became aware of changes to resident's medical condition during morning meetings. She further indicated that she was occasionally verbally told of changes by nursing staff. During a review of Resident #10's physician orders the MDS coordinator indicated that the care plan should have been update to reflect Resident #10's infection of his wound. Interview with the nurse consultant on 3/7/19 at 1:05PM revealed it was her expectation that care plans be updated to reflect the resident's current medical needs. She further revealed Resident #10's care plan should have been up dated to include an infection of the wound. Interview with the facility administrator on 3/7/19 at 4:28PM revealed it was her expectation resident care plans be updated to reflect their current medical status.	F 657		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff, nurse practitioner, and physician interviews the facility	F 658	The corrective action for the residents affected by the alleged deficient practice	4/1/19

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F 658	Continued From page 18 failed to follow a physician's order for wound care for 1 of 3 sampled residents reviewed for skin condition (Resident #19), failed to follow a physician's order for obtaining a lab for 1 of 2 sampled residents reviewed for pressure ulcer (Resident #10), and failed to follow a physician's order to provide a snack for 1 of 1 resident sampled for nutrition (Resident #24). Findings included: 1. Resident #19 was admitted to the facility on 05/09/14. A review of the quarterly Minimum Data Set (MDS) assessment dated 01/08/19 indicated Resident #19 was cognitively impaired and required extensive assistance with bed mobility and personal hygiene and was total dependent for transfer and toileting. Resident #19's diagnoses included hypertension, peripheral vascular disease, and Alzheimer's disease. A physician's order dated 02/06/19 indicated staff were to cleanse Resident #19's left inner ankle/leg with wound cleanser, pat dry, and apply calcium alginate (absorbent material that promotes wound healing), cover with telfa (nonstick dressing), wrap with kerlix (gauze dressing) and change every second day and as needed. On 03/04/19 at 11:05 AM an observation was conducted of the Wound Nurse (WN) performing wound care on Resident #19's left ankle/leg venous stasis ulcer wound. The WN removed the prior dressing to the left ankle/leg that was dated 03/03/19 and stated the wound had silvadene (topical antibiotic) plus calcium alginate on the	F 658	were accomplished for the following residents #19 was rectified on 3/4/19 , res # 10 was rectified on 3/7/19`, and resident # 24 was rectified on 3/7/2019. 2. Residents in the facility have the potential to be effected by the alleged deficient practice. An audit on residents charts were reviewed and checked off on 3/7/19 by the night nurses to ensure that physician orders, MAR's and TAR's are being reviewed and followed and discontinued medications have been removed from the carts. Audits were completed on 3/8/2019-3/15/2018 by the Unit nurse/treatment nurse to ensure all orders were checked against the labs and accurate. 3. All nurses were in-serviced on 3/28/2019 regarding verifying physician orders before providing wound care and verifying physician orders to obtain labs by the Administrator and HR Director to ensure services provided meet professional services. 8 random resident physician orders were audits and checked against the residents charts by the Treatment/ Unit Nurse on 3/11/19-3/15/19 to ensure that orders have not changed. Nurses will sign off starting 3/18/19 on the daily snack sheets verifying receiving residents snacks.In addition, verifying physician orders before providing wound care will be include in subsequent new-hire Nurses orientation.	

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F 658	Continued From page 19 wound. The WN cleansed the left ankle/leg wound with wound cleanser, patted the wound dry, applied calcium alginate, covered the wound with telfa, and wrapped the left ankle/leg with kerlix, as per physician's order. The left ankle/leg wound was observed with no signs and symptoms of infection, had no odor, and had a slight brownish colored drainage. On 03/04/19 at 11:15 AM an interview was conducted with the WN who stated she worked Monday through Friday and the Director of Nursing (DON) per documentation on the treatment administration record (TAR) had administered wound care to Resident #19's left ankle/leg vascular wound on 03/03/19. The WN stated when she changed the dressing on 03/04/19 that both silvadene and calcium alginate were noted on the left ankle/leg wound. The WN noted the physician had discontinued the silvadene on 01/29/19. The WN stated silvadene should not have been applied to Resident #19's left ankle/leg wound on 03/03/19. The WN further stated the left ankle/leg wound had showed no signs and symptoms of infection. On 03/04/19 at 2:36 PM an interview was conducted with the DON who stated the facility did not have a wound treatment nurse on 03/03/19 and she performed wound care to Resident #19's left ankle/leg. The DON indicated she did not verify the physician's wound treatment order prior to performing wound care on Resident #19's left ankle/leg and applied silvadene which had been discontinued by the physician. The DON stated she assumed the physician had ordered silvadene in addition to calcium alginate as the wound treatment for Resident #19's left ankle/leg wound. The DON further stated she	F 658	4. Monitoring in order to ensure compliance regarding Services Provided Meet Professional Standards: Starting 3/19/19 the Administrator and or Acting DON will audit resident physician orders per week x□s 4 weeks then 3 per week x□s 4 weeks. In addition, the unit nurse and or DON will look at the daily orders and check them against the labs and sign off 5x's week x's 4 weeks. Nurses will complete medication carts audits one (1) x per week x 3 months than one (1) x per week x 2 months to ensure all medications are dated, are labeled appropriately, and no meds have expired if so discarded according to the State and Federal guidelines and to make sure solutions are sustain. Data will be summarized and presented to the facility Quality Assurance Performance Improvement Committee meeting monthly x 2 months by the Administrator and or Acting DON. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised to ensure continued compliance. The Administrator and or Acting Director of Nursing are responsible for implementing and maintaining the acceptable plan of correction. Corrective action will be completed on or before 4/1/2019.	

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should have verified the physician's order prior to performing wound care on Resident #19's left ankle/leg.

On 03/04/19 at 2:49 PM an interview was conducted with the Administrator who stated her expectation was that the physician's order would have been followed by the DON when she performed wound care on Resident #19's left ankle/leg on 03/03/19. The Administrator further stated her expectation was that the DON would have verified the physician's order prior to administering wound care for Resident #19.

On 03/04/19 at 3:33 PM a telephone interview was conducted with the physician who stated it was his expectation that his wound care order for Resident #19 would have been followed. The physician further stated his expectation was that the nurse would have verified his order prior to performing wound care for Resident #19. The physician felt no harm resulted to Resident #19 due to the application of silvadene to the left ankle/leg wound on 03/03/19.

2. Resident #10 was admitted to the facility on 08/28/2018 with a diagnosis that included Type 2 Diabetes mellitus with unspecified complications, Hypertensive chronic kidney disease with stage I through stage IV, and a stage 4 pressure wound to the coccyx. The most recent Minimum Dated Set (MDS) assessment dated 12/20/2018 revealed Resident #10 was cognitively severely impaired, required extensive assistance for turning and repositioning and had pressure ulcer Stage I or greater.

Review of Resident #10's care plan initiated 9/11/18 revealed a "focus" of resident had

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potential for pressure ulcer development related to immobility, incontinence and potential for alteration in hydration/nutrition related to medial ankle stage IV identified on 11/15/18. Right hip stage IV identified on 11/20/18, right heel unstageable identified on 10/29/18, coccyx stage IV identified on 10/22/18 and left hip that was unstageable identified on 2/5/19. The goal stated Resident #10's current pressure ulcers and non-pressure areas would show signs of healing and remain free from infections. The interventions included monitor dressing to ensure it is intact and adhering, report lose dressing to treatment nurse, and report any signs of infection and monitor lab work.

Review of Resident #10's wound culture obtained 2/22/19 reveled heavy growth of pseudomonas aeruginosa.

Review of Resident #10's wound biopsy of the coccyx obtained 2/22/19 revealed acute Osteomyelitis.

Review of physician order dated 2/26/19 stated cipro 500 milligrams (mg) for 6 weeks and IM gentamicin 0.1 percent for 6 weeks per pharmacy order.

Physician order dated 2/26/19 stated Gentamicin 80mg intramuscularly (IM) every 24 hours. The order continued with draw trough before 3rd dose (3/1/19) and at Peak after 3rd (3/1/19) dose and creating level (3/1/19) per pharmacy and physician.

Review of Resident #10's medical record revealed no lab for trough, Peak or creatine level to be drawn on the 3rd day (March 1, 2019) per

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physician and pharmacy recommendations.

Interview with the Medical Director on 3/6/19 at 3:37 PM revealed it was his expectation that labs be obtained as ordered.

Interview with the Nurse Consultant on 3/7/19 at 1:05PM revealed after review of the facilities records the facility missed obtaining the lab for Trough, Peak and Creatine after the 3rd dose of Gentamicin. She further indicated the lab should have been drawn on 3/1/19. She stated the Trough was obtained on 3/4/19 and the facility had not completed the Peak or the Creatine level as of 3/7/19.

Interview with the facilities Nurse Practitioner on 3/7/19 at 3:39PM revealed the pharmacy managed the labs and the facility would be responsible for obtaining the lab. It would be preferable that the labs were drawn as ordered.

Interview with the facility Administrator on 3/7/19 at 4:28PM revealed it was her expectation that labs orders be obtained as ordered by the physician. She further indicated Resident #10's labs should have been obtained on 3/1/19 as identified by the physician order.

3. Resident #24 was admitted to the facility on 07/05/18 with multiple diagnoses that included dysphagia (difficulty swallowing).

A review of Resident #24's medical record revealed an order dated 11/13/18 which read, "continue regular mechanical soft diet; supplement: sandwich at 3:00 PM."

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Further review of the medical record revealed a diet requisition form dated 11/13/18 which read in part, "sandwich at 3:00 PM."

A review of the quarterly Minimum Data Set (MDS) dated 01/15/19 indicated Resident #24 had severe impairment in cognition and required supervision with set-up assistance for eating. The MDS further indicated Resident #24 received a mechanically altered diet and had no significant weight loss or gain during the MDS assessment period.

A review of Resident #24's nutrition care plan, with a revised date of 01/31/19, revealed she was at risk for choking and skin breakdown related to poor intake at meals. Interventions included for staff to provide and serve supplements as ordered.

A continuous observation was conducted on 03/04/19 at 2:50 PM to 3:20 PM. A tray of snacks, each individually labeled with resident names, was delivered by dietary staff and left on the nurses' desk to be distributed to the residents. There were no sandwiches noted on the tray or a snack labeled with Resident #24's name. Staff were not observed delivering a snack to Resident #24.

A meal observation conducted on 03/05/19 at 1:00 PM revealed Resident #24 was served a mechanically soft diet as indicated on her meal tray card. Resident #24 ate all of the desert but did not eat any of her regular meal. An observation conducted on 03/05/19 at 3:23 PM

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revealed Resident #24 was sitting upright in bed making repetitive hand movements. There was no snack observed.

During an interview on 03/05/19 at 10:48 AM, the Dietary Cook (DC) revealed snacks were prepared for residents with a physician's order to be delivered at 10:00 AM and 3:00 PM daily. The DC explained they were short-staffed and 10:00 AM snacks were not provided to the residents as ordered.

During an interview on 03/05/19 at 4:05 PM, Dietary Aide (DA) #1 confirmed he was responsible for preparing afternoon snacks to be delivered to the residents at 3:00 PM. The DA stated he forgot to prepare snacks for the residents and no afternoon snacks were provided on 03/05/19.

During an interview on 03/06/19 at 3:33 PM, Nurse Aide (NA) #3 revealed dietary staff brought out snacks mid-morning and afternoon for the NAs to deliver to the residents. She added the snacks delivered were labeled with the resident's name which were usually juice and crackers. She did not recall ever seeing a sandwich brought out on the tray as a scheduled snack. NA #3 stated there were times the nurses would get a sandwich for Resident #24 "to calm her down" but indicated it was not on a routine basis. NA #3 confirmed she had never provided a sandwich or snack to Resident #24.

During an interview on 03/05/19 at 12:32 PM, the

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F 658	Continued From page 25 Medical Director (MD) stated Resident #24's appetite was very erratic and there were times she wouldn't eat. He explained he wrote the order for her to receive a sandwich as a snack at 3:00 PM so she would have something to eat on the days she didn't eat her lunch. The MD stated he would expect for the snack to be provided as ordered. During an interview on 03/07/19 at 1:52 PM, the Administrator explained she printed labels for dietary staff to place on the snacks for distribution to residents as ordered and confirmed a label was included for Resident #24. The Administrator stated it was her expectation for snacks to be provided as ordered.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to provide nail care for 1 of 5 dependent residents (Resident #13). The findings included: Resident #13 was admitted to the facility on 12/17/18 with a diagnosis that included Hemiplegia and Hemiparesis following cerebral infraction affecting left non-dominate side, adult failure to thrive, moderate protein-calorie malnutrition, Parkinson's disease, Alzheimer's	F 677	Nail Care was provided on resident # 13 by the C.N.A on 3/4/19 resident has pruritus which causes resident #13 to scratch consistently. 2. All Residents have the potential to be affected by the alleged deficient practice; the Administrator completed an audit on 03/08/2019-3/15/2019 to ensure that no other resident was affected. 3. Certified nursing assistants received	4/1/19

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F 677	Continued From page 26 disease and gastro-esophageal reflux disease. The most recent Minimum Data Set (MDS) assessment dated 12/17/18 revealed Resident #13 required limited assistance with eating, extensive assistance with personal hygiene and was moderately cognitively impaired. Review of Resident #13 care plan revealed no care plan for Activities of Daily living. Observation on 3/3/19 at 12:57 pm revealed resident to be in her room. During the observation a family member was present while resident meal tray was being set up. Staff member (name unknow) was observed to set up Resident #13's meal tray on the bedside table. The resident was observed to have a brown and black substance underneath the nails of her right hand. The brown substance was present while resident ate food items by hand. Interview with Resident #13's family member on 3/3/19 at 12:59 pm revealed the substance underneath Resident #13's nails were most likely fecal matter because Resident #13 would rectally dig occasionally. She indicated Resident #13's nails normally looked like that. Interview with Resident #13 on 3/3/19 at 1:05 pm revealed she was unaware of when her nails were last cleaned. Observation of Resident #13 on 3/3/19 at 3:51 pm revealed the resident to be seated in front of the nursing station covered with a blanket. The residents right hand could be observed clutching the top of the blanket. The fingernail of resident's right hand were observed to have brown matter underneath.	F 677	in-service on Performing nail care on 3/8/19 and How to perform nail care on 3/31/2019 on residents requiring assistance. The education will continue to be included in subsequent new-hire orientation. 4.The Administrator and or designee will continue to randomly checked compliance starting 3/18/19 of Certified Nursing Assistants providing ADL care including toileting and nail care- 6 residents per week x 5 weeks, then 3 residents per week x 4 weeks. Data will be summarized and presented to the facility Quality Assurance Performance Improvement Committee meeting monthly x 2 months by the Administrator and or Acting DON. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised to ensure continued compliance. The Administrator and or Acting Director of Nursing are responsible for implementing and maintaining the acceptable plan of correction. Corrective action will be completed on or before 4/1/2019.	

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Observation of Resident #13 on 3/4/19 at 8:48 am revealed the resident to be eating breakfast in the main dining room. The fingernails of her right hand were observed to have a brown substance underneath.

Observation of Resident #13 on 3/4/19 at 4:11 pm revealed the resident to be receiving nail care by Nursing Assistant (NA) #4. Resident #13 was not resistive to care.

Interview with NA #4 on 3/4/19 at 4:13 pm revealed she had noticed the brown substance underneath Resident #13's nails which prompted her to clean and cut them. NA#4 further indicated that she had worked with Resident #13 yesterday (3/3/19) but she did not recall seeing any brown or black substance underneath her nails.

Interview with the Nurse Consultant on 3/7/19 at 1:24 pm revealed it was communicated to her that Resident #13 would rectally dig. She further revealed it was her expectation that residents received nail care and their hands cleaned prior to dining.

Interview with NA#2 on 3/7/19 at 1:28 pm revealed she had provided Resident #13 with a bath but did not complete nail care. She stated she wasn't looking at her nails to identify any substance underneath Resident #13 nails.

Interview with the facility Administrator on 3/7/19 at 4:28PM revealed it was her expectation that residents received assistance with nail care and have hands cleaned prior to dining. She further indicated it was important to ensure hand hygiene was completed due to Resident #13 being

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F 677	Continued From page 28 observed to rectally dig.	F 677		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to assess the need for the use of side rails for 2 of 2 residents reviewed for side rails (Residents #15 and #28). Findings Included: 1. Resident #15 was admitted to the facility on 09/28/17 with multiple diagnoses that included Alzheimer's disease, end-stage renal disease,	F 700	The corrective action for the residents affected by the alleged deficient practice were accomplished on Resident #28 on 3/8/19 and resident # 15 on 3/29/19. 2. Residents with side rails have the potential to be affected by this cited deficiency. Residents with side rails were reassessed on 3/28/19 by the COTA and Registered Nurse for the use of side rails.	4/1/19

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F 700	Continued From page 29 diabetes, and chronic pain. Review of the annual Minimum Data Set (MDS) dated 01/01/19 indicated Resident #15 had moderate impairment in cognition and required extensive to total staff assistance with all activities of living except for eating. Side rails were not coded as being used during the MDS assessment period. Review of the care plans for Resident #15, with a revised date of 01/23/19, revealed no care area, goal or interventions for the use of side rails. Review of Resident #15's medical record revealed the most recent side rail assessment was a quarterly dated 10/16/18. The side rail assessment form did not include a summary of the evaluation factors, other interventions used, or rationale for the continued use of side rails. The side rail assessment was not signed by the person completing the form. Observations conducted on 03/03/19 at 11:55 AM, 03/04/19 at 9:06 AM and 03/06/19 at 6:02 AM revealed Resident #15 was lying in bed in a supine (lying face upward) position with half side rails located at the head of the bed and in the upright position on both the right and left side. During these observations, Resident #15 made no attempt to use the side rails to move or reposition himself. During an interview on 03/07/19 at 9:51 AM Nurse Aide (NA) #2 revealed Resident #15 required total staff assistance for bed mobility and transfers. NA #2 confirmed both the right and left side rails were always used whenever Resident #15 was lying in bed.	F 700	COTA completed an audit on bed rails 3/28/19-3/31/19 and found no additional residents to be assessed for side rails. COTA will be responsible for notifying nurses of any residents that are in need of bed rails and updated SR assessments. 3. Licensed Nurses were re-educated by the Administrator to the use of bed rails and assessing residents for positioning as of 3/11/2019. The side rail assessments will be completed within 14 days upon admission, when a significant change occurs, quarterly, and annual in order to ensure compliance. In addition; the above education will be included in subsequent new-hire orientations. 4.Montoring performance to make sure that solutions are sustained:The Side rail use assessments will continue to be audited starting 4/1/2019 1 x's per week x 3 month and 1 x per week x' 1 month by the Director of Nursing, and or Licensed Nurses.Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise, and the plan will be revised to ensure continued compliance. Data will be summarized and presented to the facility Quality Assurance Performance Improvement Committee meeting monthly x 3 months by the Administrator and or Acting DON. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised to ensure continued	

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F 700	Continued From page 30 During an interview on 03/07/19 at 11:17 AM, the MDS Coordinator explained she started her employment with the facility on 01/24/19 and transitioned to the MDS position on 02/04/19. She was not aware of the facility's protocol for completing side rail assessments or how often they were due. The MDS Coordinator confirmed she had not completed a side rail assessment for Resident #28 since starting her employment with the facility. During an interview on 03/07/19 at 3:23 PM, Nurse #1 confirmed Resident #15 used side rails on both sides of the bed due to his increased risk of falls. She confirmed the hall Nurse was responsible for completing side rail assessments when notified by the MDS Coordinator they were due. Nurse #1 added she had been employed at the facility for 4 months and during that time she was not informed any side rail assessments were due or completed any side rail assessments for Resident #15. During an interview on 03/07/19 at 11:55 AM the Corporate Nurse Consultant (CNC) confirmed licensed nurses were responsible for completing side rail assessments when due. The CNC stated it was her expectation for resident's utilizing side rails to have an assessment completed quarterly. During an interview on 03/07/19 at 1:52 PM the Administrator stated it was her expectation for side rail assessments to be completed within 24 hours of a resident's admission to the facility and then quarterly. 2. Resident #28 was admitted to the facility on	F 700	compliance. The Administrator and or Acting Director of Nursing are responsible for implementing and maintaining the acceptable plan of correction. Corrective action will be completed on or before 4/1/2019.	

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07/11/18 with multiple diagnoses that included left-sided hemiplegia (paralysis on one side of the body), dementia, and muscle weakness.

Review of the quarterly Minimum Data Set (MDS) dated 01/22/19 indicated Resident #28 had moderate impairment in cognition and required total staff assistance with all activities of living except for eating. Side rails were not coded as being used during the MDS assessment period.

Review of the care plans for Resident #28, with a revised date of 10/30/18, revealed no care area, goal or interventions for the use of side rails.

Review of Resident #28's medical record revealed the most recent side rail assessment completed was a quarterly dated 10/17/18. The side rail assessment form included a summary of the evaluation factors which indicated Resident #28 used side rails on the right and left side of the bed as an enabler to promote independence.

An observation conducted on 03/04/19 at 3:02 PM revealed Resident #28 lying in a supine position (lying face upward) up against the right side of the bed close to the wall. The right side of Resident #28's bed was pushed up against the wall with a fall mat positioned lengthwise between the bed and wall. A side rail on the left side located at the head of the bed was noted to be in the upright position. Additional observations conducted on 03/05/19 at 3:06 PM and 03/06/19 at 6:01 AM revealed the half side rail was in the upright position while Resident #28 was lying in bed. During these observations, Resident #28 made no attempt to use the side rail to move or reposition himself.

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During an interview on 03/07/19 at 9:51 AM Nurse Aide (NA) #2 revealed Resident #28 required total staff assistance and stayed in the same position when lying in bed until turned and repositioned by staff. NA #2 confirmed the left side rail was always used whenever Resident #28 was lying in bed.

During an interview on 03/07/19 at 11:17 AM, the MDS Coordinator explained she started her employment with the facility on 01/24/19 and transitioned to the MDS position on 02/04/19. She was not aware of the facility's protocol for completing side rail assessments or how often they were due. The MDS Coordinator confirmed she had not completed a side rail assessment for Resident #28 since starting her employment with the facility.

During an interview on 03/07/19 at 3:23 PM, Nurse #1 confirmed Resident #28 used side rails when lying in bed. She confirmed the hall Nurse was responsible for completing side rail assessments when notified by the MDS Coordinator they were due. Nurse #1 added she had been employed at the facility for 4 months and during that time she was not informed any side rail assessments were due or completed any side rail assessments for Resident #28.

During an interview on 03/07/19 at 11:55 AM the Corporate Nurse Consultant (CNC) confirmed licensed nurses were responsible for completing side rail assessments when due. The CNC stated it was her expectation for resident's utilizing side rails to have an assessment completed quarterly.

During an interview on 03/07/19 at 1:52 PM the

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F 700	Continued From page 33 Administrator stated it was her expectation for side rail assessments to be completed within 24 hours of a resident's admission to the facility and then quarterly.	F 700		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and	F 756		4/1/19

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F 756	Continued From page 34 maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff, Pharmacist Consultant and physician interviews, the physician failed to provide a timely response to the Pharmacist Consultant's recommendation for a gradual dose reduction of psychoactive medications for 1 of 5 residents reviewed for unnecessary medications (Resident #41). Findings included: Resident #41 was admitted to the facility on 01/30/19 with a diagnosis of Alzheimer's dementia. A review of a physician's order for Resident #41, dated 01/30/19, indicated Zyprexa (antipsychotic) 7.5 milligrams (mg) per PEG tube (percutaneous endoscopic gastrostomy) at bedtime for behaviors. A review of Resident #41's medical record revealed on 02/06/19 the Pharmacist Consultant (PC) recommended consideration of a Gradual Dose Reduction (GDR) for Zyprexa. A review of the admission Minimum Data Set (MDS), dated 02/16/19, revealed Resident #41 had severe cognitive impairment. Further review of the MDS indicated Resident #41 had trouble concentrating on things but had no behaviors during the assessment period.	F 756	1.On 3/07 /19 the physician reviewed resident #41 medical record and addressed the Pharmacy recommendation. 2.Resident□s with Pharmacy Consultant recommendation consideration of a Gradual Dose Reduction have the potential to be affected by this cited deficiency that the physician failed to provide a timely response to the Pharmacy Consultant□s Recommendation for a gradual dose reduction of psychoactive medication. 3.The Administrator on 3/19/19 re-educated the Physician and Director of Nursing when the pharmacy recommendation report is received from the Pharmacy Consultant via email the recommendations will be given to the Director of Nursing and healthcare provider, either the physician or nurse practitioner. The DON have audited the March recommendations on 3/11/2019 and informed the physician of any recommendations that required his additional attention. The Director of Nursing will continue to follow-up with the Medical Director via	

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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 756	Continued From page 35 A review of Resident #41's medical record revealed on 03/04/19 the PC had a pending recommendation consideration of a GDR for Zyprexa. During an interview on 03/06/19 at 12:55 PM, the PC indicated no response from the health care provider was received for Resident #41's GDR recommendation, dated 02/06/19, during his monthly review on 03/04/19. The PC explained the process of how the monthly pharmacy recommendation report was sent to the facility. He further explained that the monthly report was sent via email to the Director of Nursing (DON), Administrator, and Medical Director. He stated the facility should then take the recommendations and give them to the health care provider, either the physician or nurse practitioner. The PC further stated the provider would review the recommendation and would make a response. The PC revealed the provider would write an order for the recommendation or write a statement to justify continuation of the medication. From that point, the PC further revealed the recommendation form was then filed in the medical records chart under the pharmacy or consult tab and if there was an order, the nursing staff would write the order. The PC stated the next month he would look under the pharmacy or consult tab in the chart. He further stated his expectation was the GDR should be completed within the first 2 weeks after a resident was admitted to the facility to determine if a resident needed to still be on the psychotropic medication, Zyprexa and evaluated quarterly thereafter. During an interview on 03/05/19 at 12:15 PM, the	F 756	phone and during his weekly visits when Pharmacy recommendations are made in order to ensure that the deficient practice will not recur. Audits were completed on 3/12/19 and 3/19/19. 4.Monitoring:Pharmacy Recommendations regarding the medication regimen review will be audited every two weeks x 3 months starting 3/12/19 by the Director of Nursing, Licensed Nurse and or Administrator to ensure that the physician has responded and signed the pharmacy recommendation in order to ensure the solutions are sustained. 5.Data will be summarized and presented to the facility QA Committee meeting monthly x's three (3)months by the Administrator and or designee.Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise, and the plan will be revised to ensure continued compliance. 5.The Administrator and or Director of Nursing are responsible for implementing and maintaining the acceptable plan of correction. Corrective action will be completed on or before 4/1/2019.	

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F 756	Continued From page 36 physician stated he thought pharmacy recommendations may have slipped through the cracks due to staffing issues. He further stated that a GDR should have been completed. He indicated that the previous DON may not have been taking care of pharmacy recommendations. He further indicated he did not know what happened to the February 6th pharmacy recommendations. He revealed that usually his nurse practitioner reviewed the recommendations and took care of most of them, but he stated he did not know if the nurse practitioner looked at the recommendations or not. The Director of Nursing (DON) was not available to answer any questions. During an interview on 03/07/19 at 10:30 AM, the Corporate Nurse Consultant indicated her expectations would be that pharmacy recommendations would be addressed and followed up by the DON and healthcare provider within one week after the recommendation was made. During an interview on 03/07/19 at 1:15 PM, The Administrator indicated that the PC would send his recommendation via email to the her late at night and on the next day she was not able to go through all the emails to review the PC's recommendations. She further indicated that the physician, PC, and she were not always present on the same day that the PC made his recommendations. The Administrator revealed she would expect for the physician to provide a response to the PC's recommendations within 24 hours after the recommendation was made.	F 756		
F 758	Free from Unnec Psychotropic Meds/PRN Use	F 758		4/1/19

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F 758 SS=D	Continued From page 37 CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is	F 758		

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F 758	Continued From page 38 appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and Pharmacy Consultant, Nurse Consultant, and Physician's interview the facility failed to ensure a specific duration order was obtained for a psychotropic drug for 1 of 5 residents reviewed for unnecessary medication use (Resident #5). Resident #5 was admitted to the facility on 10/8/15 with diagnoses which included Alzheimer's dementia, anxiety, and depression. Review of the most recent annual Minimum Data Set (MDS) assessment dated 12/4/18 revealed Resident #5 was coded for severe cognitive impairment. Review of the physician's progress note dated 8/23/18 revealed a plan to continue Lorazepam (antianxiety medication) as currently ordered and reevaluate in 6 months. The Physician progress note included the current Lorazepam orders for 0.5 mg ½ tab at bedtime and 0.5 mg every 6 hours as needed (PRN) for acute episodes of agitation or anxiety. Review of the Pharmacy Medication Regimen Review dated 2/6/19 stated in part that the	F 758	1.On 3/11 /19 the physician reviewed resident #5 medical record and the order from the physician is to continue with current schedule which is PRN 2.Resident□s receiving PRN orders for anti-psychotic drugs have the potential to be affected by this cited deficiency that the facility failed to ensure a specific duration order was obtained for a psychotropic drug. Audit was completed by the Nurses on Residents that receive PRN meds on 3/11/19-3/15/19 to ensure know other residents were affected by the deficient practice. 3. Education: The Administrator have in-serviced the Physician and Director of Nursing on 3/19/2019 regarding the regulation component to provide a specific duration for antianxiety medications. 483.45 (e) (4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in 483.45 (5), if the attending physician or prescribing practitioner believes that it is appropriate	

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F 758	Continued From page 39 resident had been prescribed Lorazepam 0.25 mg at bedtime for anxiety since 3/2018 and Lorazepam 0.5 mg every 6 hours PRN for anxiety since 11/2016. The Pharmacist noted duration of PRN Lorazepam order ended 2/2019 and a specific duration of the PRN Lorazepam must be provided with any new order per CMS regulations. An interview was conducted with the Pharmacy Consultant on 3/7/19 at 11:59 AM revealed he had written a pharmacy recommendation to the Physician on 2/6/19 for a duration for the PRN Lorazepam. The Pharmacy Consultant explained he emailed the pharmacy recommendations to the Administrator and Director of Nursing (DON) the day he visits the facility. The Pharmacy Consultant noted the 2/6/19 recommendation had not been addressed at the time of his review on 3/4/19 and he had resent the recommendation. Interview with the Physician on 3/6/19 at 3:40 PM revealed that due to the pharmacy recommendations being emailed they might not have reached the new DON and therefore he would not have received the pharmacy recommendations in a timely manner. The Physician also stated he did not receive the 2/6/19 pharmacy recommendation and did not know what happened to it and was unaware of what recommendations the pharmacy had made on 3/4/19. The interview further revealed the Physician was aware it was the CMS regulation to provide a specific duration for antianxiety medications. Interview with the Corporate Nurse Consultant on 3/6/19 at 3:25 PM revealed she was unaware the pharmacy recommendations were not being	F 758	for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident□s medical record and indicate the duration for the PRN order in order to ensure the deficient practice will not recur. The above regulations will be included in subsequent new-hire orientations 4. Monitoring in order to ensure that solutions are sustained 5 residents PRN orders for antipsychotic drugs,5 residents psychotropic drugs, and 5 residents new orders will be audited monthly x 3 months starting 3/20/19 by the Acting DON or a Licensed Nurse. Data will be summarized and presented to the facility QA Committee monthly x's three (3)months by the Director of Nursing and or Licensed Nurse. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise, and the plan will be revised to ensure continued compliance. 5.The Director of Nursing and or licensed Nurse are responsible for implementing and maintaining the acceptable plan of correction. Corrective action completed on 4/01/2019	

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F 758	Continued From page 40 handled in a timely manner. She was aware of the CMS regulation to provide a specific duration for antianxiety medications. The Corporate Nurse Consultant was aware the pharmacy recommendations were emailed to the DON and Administrator, but was unaware if the new DON had received them. The interview further revealed the Corporate Nurse Consultant expected the pharmacy recommendations to be printed out and given to the Physician for his review as soon as the DON received the email. Interview with the Administrator on 3/7/19 at 11:25 AM revealed she was unaware the pharmacy recommendations from February had not been communicated to the Physician and she was aware of the CMS regulation to provide a specific duration for antianxiety medications. The Administrator's expectation was for the DON to print the pharmacy recommendations when they were received and ensure the Physician addressed them the next time he was at the facility.	F 758		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and	F 761		4/1/19

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F 761	Continued From page 41 biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to discard an opened Victoza insulin Flex Pen that was not dated when opened, an opened Levemir 10 milliliter (ml) insulin vial that was outdated, an opened NovoLog 10 ml insulin vial that was outdated, a Lantus insulin FlexPen that was not dated when opened, and an opened NovoLog insulin Flex Pen that was not dated when opened and were available for use in 1 of 2 medication carts. Findings included: 1. a. A review of the manufacturer's recommendations indicated Victoza insulin Flex Pen had to be discarded 30 days after opening. Resident #14 was admitted to the facility on 05/14/15 with diagnosis of diabetes mellitus. A physician's order dated 09/01/17 indicated Resident #14 was to receive Victoza insulin Flex Pen 18 milligram (mg) per 3 milliliter (ml) inject 1.8 mg subcutaneously (under skin) daily 6:00	F 761	1. Resident #14 Victoza Insulin Flex Pen opened and undated was discarded by the Nurse Consultant on 3/5/19. Resident #15 Levemir Insulin with an open date of 01/16/19 was discarded by the Nurse Consultant on 3/5/19. Resident #10 Novolog Insulin vial dated 01/16/19 was discarded by the Nurse Consultant on 3/5/19.Resident #9 Lantus insulin Flex Pen and Novolog Insulin Flex Pen were open and undated was discarded by the Nurse Consultant on 3/5/19. 2.Resident□s receiving medications have the potential to be affected by this cited deficiency that the facility failed to discard insulin that was not dated when opened and insulin that was expired. Audit of medication carts were completed by License Nurses on 03/06/19 any concerns identified were immediately corrected. . 3.Re-education was completed by the	

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F 761	Continued From page 42 AM for diabetes mellitus. On 03/05/19 at 10:55 AM Resident #14's Victoza insulin Flex Pen was observed on medication cart #2 ready for resident use and was opened and undated. On 03/05/19 at 11:00 AM an interview was conducted with Nurse #1 who stated Resident #14's Victoza insulin Flex Pen was on medication cart #2 ready for resident use. Nurse #1 stated she had not administered Victoza insulin Flex Pen to Resident #14. Nurse #1 stated the facility policy was to date insulin when opened. Nurse #1 stated without an opened date there was no way to determine when Resident #14's Victoza insulin Flex Pen had expired. On 03/05/19 at 11:21 AM an interview was conducted with the Corporate Nurse (CN) who stated her expectation was that nursing staff would have dated the Victoza insulin Flex Pen for Resident #14 when it was opened as per facility protocol. The CN stated because Resident #14's Victoza insulin Flex Pen had not been dated when opened and there was no way to determine when the insulin had expired. The CN removed Resident #14's Victoza insulin from medication cart #2. The CN stated the medication cart audits for expired and undated medications had not been conducted. On 03/05/19 at 11:31 AM an interview was conducted with the Director of Nursing (DON) who stated her expectation was that staff would have dated Resident #14's Victoza insulin Flex Pen when opened. The DON stated because Resident #14's Victoza insulin Flex Pen had not been dated when open then there was no way to	F 761	Director of Nursing and or Licensed Nurse on 03/08/19 to the start of the licensed Nurse next shift; regarding F761 and the policy for labeling and storage of drugs and biologicals for Licensed Nursing staff. Audits were completed for the medication carts on 03/08/19-03/15/19 by the Director of Nursing and Licensed Nurse to ensure that no other expired or open and undated medications were available for usage and that insulins were appropriately labeled and dated as to when they were opened based on manufactures guidelines in order to ensure that the deficient practice does not recur. 4.Monitoring performance in order to ensure solutions are sustained The Director of Nursing, MDS Coordinator, Licensed Nurses will complete medication carts audits one (1) x per week x 3 months than one (1) x per week x 2 months starting 3/16/19 to ensure all medications are dated, are labeled appropriately, and no meds have expired if so discarded according to the State and Federal guidelines. Results of these audits will be reported to the QAPI Committee meeting one (1)x per month x's 4 months by the Administrator and or designee. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise, and the plan will be revised to ensure continued compliance.	

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F 761	Continued From page 43 determine when the insulin had expired. The DON stated there was no system in place for checking outdated or expired medication. On 03/05/19 at 11:39 AM an interview was conducted with the Administrator who stated her expectation was that insulin would have been dated when opened as per facility policy. The Administrator stated there was no system in place for checking outdated or expired medication. b. A review of the manufacturer's recommendations indicated Levemir insulin vial had to be discarded 42 days after opening. Resident #15 was admitted to the facility on 11/08/17 with diagnosis of diabetes mellitus. A physician's order dated 09/28/17 indicated Resident #15 was to receive Levemir insulin 100 units/ml vial inject 10 units subcutaneously at bedtime for diabetes mellitus. On 03/05/19 at 10:55 AM Resident #15's Levemir insulin 10 ml vial dated 01/16/19 when opened was observed on medication cart #2 ready for resident use and was expired. On 03/05/19 at 11:00 AM an interview was conducted with Nurse #1 who stated Resident #15's Levemir insulin vial was on medication cart #2 ready for resident use. Nurse #1 stated she had not administered Levemir insulin to Resident #15. Nurse #1 stated the facility policy was to date insulin when opened and discard when expired. Nurse #1 stated Resident #15's Levemir insulin vial had expired and should have been discarded.	F 761	5.The Administrator and or Director of Nursing are responsible for implementing and maintaining the acceptable plan of correction.	

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F 761	Continued From page 44	F 761		

On 03/05/19 at 11:21 AM an interview was conducted with the Corporate Nurse (CN) who stated her expectation was that nursing staff would have discarded the expired Levemir insulin vial dated 01/16/19 for Resident #15 per facility protocol. The CN removed Resident #15's expired Levemir insulin vial from medication cart #2. The CN stated the medication cart audits for expired and undated medications had not been conducted.

On 03/05/19 at 11:31 AM an interview was conducted with the Director of Nursing (DON) who stated her expectation was that staff would have discarded Resident #15's expired Levemir insulin vial dated 01/16/19. The DON stated there was no system in place for checking outdated or expired medication.

On 03/05/19 at 11:39 AM an interview was conducted with the Administrator who stated her expectation was that staff would have discarded expired insulin as per facility policy. The Administrator stated there was no system in place for checking outdated or expired medication.

c. A review of the manufacturer's recommendations indicated NovoLog insulin vial had to be discarded 28 days after opening.

Resident #10 was admitted to the facility on 12/07/18 with diagnosis of diabetes mellitus.

A physician's order dated 12/18/18 indicated Resident #10 was to receive NovoLog insulin 100 units/ml vial for sliding scale 8:00 AM, 12:00 PM, 4:00 PM and 8:00 PM.

On 03/05/19 at 10:55 AM Resident #10's

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F 761	Continued From page 45	F 761		

NovoLog insulin vial dated 01/16/19 when opened was observed on medication cart #2 ready for resident use and was expired for 20 days.

On 03/05/19 at 11:00 AM an interview was conducted with Nurse #1 who stated Resident #10's NovoLog insulin vial was on medication cart #2 ready for resident use. Nurse #1 stated she had not administered NovoLog insulin to Resident #10. Nurse #1 stated the facility policy was to date insulin when opened and discard when expired. Nurse #1 stated Resident #10's NovoLog insulin vial had expired and should have been discarded.

On 03/05/19 at 11:21 AM an interview was conducted with the Corporate Nurse (CN) who stated her expectation was that nursing staff would have discarded the expired NovoLog insulin vial dated 01/16/19 for Resident #10 per facility protocol. The CN removed Resident #10's expired NovoLog insulin vial from medication cart #2. The CN stated the medication cart audits for expired and undated medications had not been conducted.

On 03/05/19 at 11:31 AM an interview was conducted with the Director of Nursing (DON) who stated her expectation was that staff would have discarded Resident #10's expired NovoLog insulin vial dated 01/16/19. The DON stated there was no system in place for checking outdated or expired medication.

On 03/05/19 at 11:39 AM an interview was conducted with the Administrator who stated her expectation was that staff would have discarded expired insulin as per facility policy. The Administrator stated there was no system in place

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F 761	Continued From page 46	F 761		

for checking outdated or expired medication.

d. A review of the manufacturer's recommendations indicated Lantus insulin Flex Pen had to be discarded 28 days after opening and Novolog insulin Flex Pen had to be discarded 28 days after opening.

Resident #9 was admitted to the facility on 12/17/18 with diagnosis of diabetes mellitus.

A physician's order dated 12/11/18 indicated Resident #9 was to receive Lantus insulin Flex Pen 60 units subcutaneously at bedtime.

A physician's order dated 03/05/19 indicated Resident #9 was to receive NovoLog insulin Flex Pen 14 units subcutaneously three times a day with meals.

On 03/05/19 at 10:55 AM Resident #9's Lantus insulin Flex Pen and NovoLog insulin Flex Pen were observed on medication cart #2 ready for resident use and were opened and undated.

On 03/05/19 at 11:00 AM an interview was conducted with Nurse #1 who stated Resident #9's Lantus and NovoLog insulin Flex Pen were on medication cart #2 ready for resident use. Nurse #1 stated she had not administered Lantus or NovoLog insulin Flex Pen to Resident #9. Nurse #1 stated the facility policy was to date insulin when opened. Nurse #1 stated without an opened date there was no way to determine when Resident #9's Lantus and NovoLog insulin Flex Pen had expired.

On 03/05/19 at 11:21 AM an interview was conducted with the Corporate Nurse (CN) who

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F 761	Continued From page 47 stated her expectation was that nursing staff would have dated the Lantus insulin Flex Pen and the NovoLog insulin Flex Pen for Resident #9 when they were opened as per facility protocol. The CN stated because Resident #9's Lantus and NovoLog insulin Flex pen had not been dated when opened there was no way to determine when the insulin had expired. The CN removed Resident #9's Lantus insulin Flex Pen and NovoLog insulin Flex Pen from medication cart #2. The CN stated the medication cart audits for expired and undated medications had not been conducted. On 03/05/19 at 11:31 AM an interview was conducted with the Director of Nursing (DON) who stated her expectation was that staff would have dated Resident #9's Lantus insulin Flex Pen and NovoLog insulin Flex Pen when opened. The DON stated because Resident #9's Lantus and NovoLog insulin Flex pen had not been dated when open then there was no way to determine when the insulin had expired. The DON stated there was no system in place for checking outdated or expired medication. On 03/05/19 at 11:39 AM an interview was conducted with the Administrator who stated her expectation was that insulin would have been dated when opened as per facility policy. The Administrator stated there was no system in place for checking outdated or expired medication.	F 761		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry	F 801		4/1/19

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F 801	Continued From page 48 out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.	F 801		

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F 801	Continued From page 49 §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on interviews, the facility failed to employ a Certified Dietary Manager with the competencies and skills required to carry out food and nutrition services from 2/1/19 and continuing at the time of the survey 3/3/19 through 3/7/19 for 1 of 1 Certified Dietary Manager position. Findings included:	F 801	The facility as of 3/11/2018 has hired a certified food serve manager.The facility has also employed a qualified registered dietician which started on 2/27/19 on a consultant basis. 2. No residents were identified as having been affected by the alleged deficient practice.	

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F 801	Continued From page 50 Upon initial entry into the kitchen on 3/3/19 at 10:51 AM, staff identified the Administrator as being in charge of the kitchen. Interview with the Registered Dietitian (RD) on 3/6/19 at 2:03 PM revealed she was at the facility one time the previous week and planned to be at the facility once a month. She further revealed she was aware there was no dietary manager. She also stated she did not know who was monitoring resident weights, menus or food preferences. She said her current contract with the facility was to work the second Wednesday of each month. Interview with the Administrator on 3/5/19 at 3:02 PM revealed there was no dietary manager for the facility since 2/1/19. The RD was also new and had been to the facility one time. She further stated she expected the nurses to monitor the resident's weights. The Administrator indicated no one at the facility was trained to update the resident's menu cards at this time. The interview furhterShe further stated she planned to promote a cook to the position of dietary manager but was also actively recruiting for the position. The Administrator confirmed she was in charge of food and nutrition services at the facility and she was not aware of the federal regulation for a Dietary Manager to be on the staff.	F 801	3.The Consultant has re-educated the Administrator on ensuring that a Certified Dietary Manager or Certified food serve manager is always in place according to the qualified dietary staff regulations. 4. Monitoring to ensure compliance the Regional Consultant will sign off monthly x's three months. Data will be summarized and presented to the facility Quality Assurance Performance Improvement Committee meeting monthly x 3 months by the Administrator and or Acting DON. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised to ensure continued compliance. Corrective action will be completed on or before 4/1/2019.	
F 812 SS=F	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	F 812		4/1/19

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F 812	Continued From page 51 from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to correctly store dry food items, failed to label and date food items stored in 1 of 1 walk in cooler, failed to discard moldy food items, failed to correctly clean ice machine, failed to observe correct hand/glove hygiene in the kitchen, and failed to ensure one of one kitchen dishwashers dispensed chemicals to sanitize dishes and equipment washed in the machine. Findings included: 1. Observations of the kitchen on 3/3/19 at 10:51 AM to 11:10 AM revealed: a. Unsealed flour bag in dry storage area. b. Whole eggs of unknown status in the walk in cooler in a metal container uncovered and undated. c. Box of green peppers in walk in cooler that were moldy. d. Ice machine with black substance on right wall and visible dirt and debris inside lid. e. Cook wearing 1 glove on left hand scooping food with right hand, tying food bag with both hands, then tying trash bag closed, then washing	F 812	The corrective action that was taken for the deficient practice of unsealed flour bag in dry storage area was removed and thrown out on 3/3/19, whole eggs was cover and dated with the date that they were cooked which was 3/3/19. The green peppers that were bad were discard on 3/3/19, the ice machine was cleaned on 3/3/19, the corn meal and grits were discard on 3/3/19. The cook had received in-serve on infection control on 3/3/19 by the Administrator. The PH level for the dishwasher was corrected on 3/7/19. 2.No residents were identified as having been affected by the alleged deficient practice. 3. Education was provide on 3/9/2019 to all the dietary staff regarding infection control and on 3/10/19 regarding covering and dating food by the Administrator; In addition, a cleaning schedule was put in place for the dietary department by the Administrator to ensure that the deficient	

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F 812	Continued From page 52 knife at sink, then adding spices to cooking food on stove still wearing same 1 glove. f. One unsealed bag of corn meal and one unsealed bag of grits on a shelf in kitchen. Interview with Dietary Cook #2 on 3/5/19 at 1:30 PM revealed she did not clean the ice machine in January or February. She further stated she had not placed her initials on the cleaning log as having cleaned the ice machine on the January or February cleaning logs. Interview with Dietary Cook #1 on 3/5/19 at 10:48 AM revealed when she cleaned the ice machine, she wiped the outside down. She stated she had never cleaned the inside of the ice machine. She further stated she did sign the cleaning log as having cleaned the ice machine. Interview with Dietary Aide on 3/5/19 at 2:00 PM revealed he had never cleaned the ice machine. He further stated he sometimes signed the cleaning log for cleaning the ice machine. There was no dietary manager on staff. Interview and kitchen tour with the administrator on 3/3/19 at 2:10 PM revealed her expectation that eggs would be dated and covered, green peppers would be disposed of if moldy, flour would be correctly sealed, corn meal and grits would be stored correctly, ice machine would be cleaned regularly. 2. Observations of the kitchen on 3/5/19 at 2:00 PM revealed dietary aide wearing gloves handling dirty dishes, then washed the gloves in running tap water, then put away some clean dishes, then wiped a tray cart, then put away more clean dishes still wearing same gloves. The dietary aide	F 812	practice will not recur. 4.Monitoring to ensure compliance a every two week cleaning schedule have been put in place for the ice machine and a daily/ weekly dietary cleaning schedule as of 3/7/19 the Administrator and or food service manager will audit the covering and dating food and the dish washing process 3 x's a week on all three shifts for 3 months and check for rotten food daily x's 3 months in order to ensure compliance. Data will be summarized and presented to the facility Quality Assurance Performance Improvement Committee meeting monthly x's 3 months by the Administrator and Food Service Manager. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised to ensure continued compliance. The Administrator and or Food Service Manager are responsible for implementing and maintaining the acceptable plan of correction. Corrective action will be completed on or before 4/1/2019.	

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F 812	Continued From page 53	F 812		

was asked when he changed gloves and he stated "when they get tired."

Interview with the administrator 3/5/19 at 3:15 PM revealed her expectation was the dietary aide would observe correct hand/glove hygiene and the dietary aide was instructed by the administrator to rewash all the dishes due to potential cross contamination.

There was no dietary manager on staff. Interview and kitchen tour with the administrator on 3/3/19 at 2:10 PM revealed her expectation staff would observe correct hand/glove hygiene at all times.

3. Review of the kitchen dishwashing machine's operating specifications revealed it required at least 50 parts per million (PPM) of chlorine during the machine's final rinse cycle to sanitize dishware and equipment washed in the machine and optimal chlorine titration was between 50-100 ppm.

Observation on 3/5/19 at 2:00 PM revealed a Dietary Aide was washing dishes in the kitchen dishwashing machine. Interview with the Dietary Aide on 03/05/19 at 2:00 PM revealed the aide was unaware of how to test the sanitizing agent used in the dishwashing machine. Further interview with the dietary aide revealed he had never checked the dishwasher to see if it was dispensing the correct amount of chemicals. He further stated he just signed the dish machine log 'like everybody else' and did not know how to use the test strips to check the chemical concentration being dispensed by the machine, what the correct reading should be on the machine's sanitizing agent, or what to do if the reading was incorrect.

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F 812	Continued From page 54	F 812		

Observation on 3/5/19 at 2:03 PM of the Dietary Cook #1 using chlorine test strips on 3 occasions to test the amount of sanitizing agent being dispensed by the dish machine revealed no sanitizing agent was being added by the machine to the water for sanitizing dishes.

Interview with the Dietary Cook #1 on 3/5/19 at 2:05 PM revealed she would notify the administrator and the maintenance director that the dishwasher was not working correctly. She further stated she did not know what to do about the dish machine not dispensing sanitizing agent to sanitize the dish ware. She also stated she did not normally test the dishwasher as this was usually assigned to the dietary aide.

Interview with the Maintenance Director on 3/7/19 at 1:20 PM revealed he did not handle repairs for the dishwasher due to the facility having a contract with an outside repair company.

Review of the service request emailed to the Maintenance Director by the dish machine's service company on 3/7/19 at 2:16 PM revealed the kitchen's dish washer was not dispensing any chlorine sanitizing agent on 3/5/19 because the machine's chlorine squeeze tube, the chlorine line and the chlorine roller were not working and all had to be replaced.

Observation of staff performing the dishwasher chlorine test strip process on 3/6/19 at 8:27 AM revealed there were 100 ppm chlorine in the water as per manufacturer operating instructions.

Interview with the Administrator on 3/5/19 at 3:15 PM revealed she was responsible for the kitchen

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F 812	Continued From page 55 supervision due to the absence of a Dietary Manager and it was her expectation that the dishwasher chemical test strip would read the correct amount of chlorine for sanitizing the dishes and the dishwasher performance would be checked three times per day. She further stated the facility had a contract with a dishwasher repair company and she would contact them immediately if the machine was not working properly. She also stated she would reeducate the staff about the correct amount of chlorine needed to sanitize the dishes, how to test the dishwasher performance three times daily, and staff responsibility for performance of the task when signing the logs verifying completion of the task. Interview with the Administrator on 3/7/19 at 10:42 AM revealed the dietary staff had received their training from Health Service Management but there were no records available. She further stated her expectations were for the dietary staff to follow the cleaning schedule, use safe food handling, use correct hand hygiene, and store foods appropriately.	F 812		
F 813 SS=C	Personal Food Policy CFR(s): 483.60(i)(3) §483.60(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on family interview and staff interview, the facility failed to have a policy regarding the use and storage of foods brought to residents by family to ensure safe and sanitary storage,	F 813	No residents were identified as having been affected by the alleged deficient practice.	4/1/19

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F 813	Continued From page 56 handling, and consumption for 1 of 1 resident (Resident #4). Findings included: Interview with Resident #4 family member on 3/3/19 at 11:37 AM revealed she brings food on a daily basis and she had never been provided a family food policy. Interview with the Administrator on 3/7/19 at 10:42 AM revealed the facility does not have a policy regarding food brought into the facility by family or visitors for the residents. She also stated she was unaware of a corporate policy about food brought into the facility. The interview further revealed there should be a policy and she would work on writing it.	F 813	2. In order to ensure compliance a policy was put in place on 3/7/2019 by the Administrator regarding the use and storage of foods brought to residents by family to ensure safe and sanitary storage. An audit was completed on 3/18/19 by the Social worker to determine residents that are receiving food into the facility from family. 3.Education regarding the facility policy was provided to the families by the Social Worker on 3/29/19 via mail All staff have received in-service on the facility policy on families use and storing food as of 3/8/2019.The policy will also be included in the facility Admission package. In addition, newly hired Staff will also receive education during subsequent orientation. 4.Monitoring performance to make sure that the solutions are sustained Dietary/Nursing staff will start auditing on 3/11/2019 the refrigerator behind the nursing station where resident food is stored 3x's per week x's one (1) month and then 2x's per week x's one (1) month to ensure that residents' name and date is on food, to ensure that non-perishable foods are stored in re-sealable containers, and food is discarded that show signs of foodborne danger. Data will be summarized and presented to the facility Quality Assurance Performance Improvement Committee meeting monthly x 2 months by the Administrator and or Social Worker. Any issues or trends	

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F 813	Continued From page 57	F 813	identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised to ensure continued compliance. Corrective action will be completed on or before 4/1/2019.	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and resident and staff interviews the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions that the committee had previously put into place. This failure related to two recited deficiencies that were originally cited following the 03/01/18 annual recertification survey, the 12/20/18 revisit and complaint investigation and were recited again following the 03/07/19 revisit, annual recertification survey and complaint investigation. The recited deficiencies were in the areas of Activities of Daily Living (ADL) care provided for dependent residents and food procurement, store/prepare/serve - sanitary. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program.	F 867	1. No residents were identified as having been affected by this alleged deficient practice. 2.The Administrator completed an audit on 03/08/2019-3/15/2019 regarding ADL Nail Care to ensure compliance and or identify any potential nail concerns. 3.Education:The quality Assurance Committee were in-serviced on 3/26/19 regarding the previous tags and the systems that need to be put in place. Certified nursing assistants received in-service on Performing nail care on 3/8/19 and How to perform nail care on 3/31/2019. In addition, Education regarding the facility policy was provided to the families by the Social Worker on	4/1/19

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F 867	Continued From page 58 Findings included: This tag is cross referenced to: 1. a. 483.24 ADL Care Provided to Dependent Residents: Based on observation, record review and staff interview, the facility failed to provide nail care for 1 of 5 dependent residents (Resident #13). During the revisit and complaint investigation of 12/20/18 the facility was cited for failure to provide toileting assistance and nail care to two dependent residents. b. 483.60 Food Procurement, Store/Prepare/Serve - Sanitary: Based on observations and staff interviews, the facility failed to correctly store dry food items, failed to label and date food items stored in 1 of 1 walk-in cooler, failed to discard moldy food items, failed to correctly clean ice machine, failed to observe correct hand/glove hygiene in the kitchen, and failed to ensure 1 of 1 kitchen dishwashers dispensed chemicals to sanitze dishes and equipment washed in the machine. During the annual recertification survey of 03/01/18 the facility was cited for failure to clean a dirty wall behind the dishwashing machine, label and date bags containing multiple-portion food items, remove standing water in the walk-in cooler, and defrost the stand-up freezer that had thick ice accumulation.	F 867	3/29/19 via mail. All staff have received in-service on the facility policy on families use and storing food as of 3/8/2019.The policy will also be included in the facility Admission package. Newly hired Staff will also receive education during subsequent orientation. to ensure that the deficient practice will not recur. 4.The Administrator and or Designee will be responsible for this aspect of the Plan of Correction. The Administrator and or Designee will audit to ensure interventions are still in place regarding ADL toileting/nail care audit will be done on random residents 5 x's per week x's 4 weeks. Every two week cleaning schedule have been put in place for the ice machine and a daily/ weekly dietary cleaning schedule as of 3/7/19 the Administrator and or food service manager will audit the covering and dating food and the dish washing process 3 x's a week on all three shifts for 3 months and check for rotten food daily x's 3 months in order to ensure compliance. Data will be summarized and presented to the facility Quality Assurance Performance Improvement Committee meeting monthly x 2 months by the Administrator and or Acting DON. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised to ensure continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	A. BUILDING _____ B. WING _____	C 03/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWWOOD NURSING CENTER	4414 WILKINSON BLVD GASTONIA, NC 28056

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F 867	Continued From page 59 During an interview on 03/07/19 at 4:08 PM the Administrator explained their focus had been on correcting and monitoring the identified areas of concern and she felt the systems put into place to correct the deficiencies broke down due to the time it took to figure out the issues and research solutions for compliance. The Administrator stated plans would be developed with a stronger emphasis on monitoring to ensure compliance was maintained.	F 867	The Administrator and or Acting Director of Nursing are responsible for implementing and maintaining the acceptable plan of correction. Corrective action will be completed on or before 4/1/2019.	

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F 000	INITIAL COMMENTS On 03/07/19, the Division of Health Service Regulation, Nursing Home Licensure and Certification conducted an onsite revisit. While some deficiencies cited on the complaint investigation on 01/17/19 were corrected effective 02/08/19, the facility remains out of compliance.	F 000		
{F 677} SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to provide nail care for 1 of 5 dependent residents (Resident #13). The findings included: Resident #13 was admitted to the facility on 12/17/18 with a diagnosis that included Hemiplegia and Hemiparesis following cerebral infraction affecting left non-dominate side, adult failure to thrive, moderate protein-calorie malnutrition, Parkinson's disease, Alzheimer's disease and gastro-esophageal reflux disease. The most recent Minimum Data Set (MDS) assessment dated 12/17/18 revealed Resident #13 required limited assistance with eating, extensive assistance with personal hygiene and was moderately cognitively impaired. Review of Resident #13 care plan revealed no care plan for Activities of Daily living.	{F 677}	Nail Care was provided on resident # 13 by the C.N.A on 3/4/19 resident has pruritus which causes resident #13 to scratch consistently. 2. All Residents have the potential to be affected by the alleged deficient practice; the Administrator completed an audit on 03/08/2019-3/15/2019 to ensure that no other resident was affected. 3. Certified nursing assistants received in-service on Performing nail care on 3/8/19 and How to perform nail care on 3/31/2019 on residents requiring assistance. The education will continue to be included in subsequent new-hire orientation. 4.The Administrator and or designee will continue to randomly checked compliance starting 3/18/19 of Certified Nursing	4/1/19

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

Electronically Signed | 04/01/2019

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 677}	Continued From page 1 Observation on 3/3/19 at 12:57pm revealed resident to be in her room. During the observation a family member was present while resident meal tray was being set up. Staff member (name unknow) was observed to set up Resident #13's meal tray on the bedside table. The resident was observed to have a brown and black substance underneath the nails of her right hand. The brown substance was present while resident ate food items by hand. Interview with Resident #13's family member on 3/3/19 at 12:59pm revealed the substance underneath Resident #13's nails were most likely fecal matter because Resident #13 would rectally dig occasionally. She indicated Resident #13#s nails normally looked like that. Interview with Resident #13 on 3/3/19 at 1:05 pm revealed she was unaware of when her nails were last cleaned. Observation of Resident #13 on 3/3/19 at 3:51 pm revealed the resident to be seated in front of the nursing station covered with a blanket. The residents right hand could be observed clutching the top of the blanket. The fingernail of resident's right hand was observed to have brown matter. Observation of Resident #13 on 3/4/19 at 8:48 am revealed the resident to be eating breakfast in the main dining room. The fingernails of her right hand were observed to have a brown substance. Observation of Resident #13 on 3/4/19 at 4:11 pm revealed the resident to be receiving nail care by Nursing Assistant (NA) #4. Resident #13 was not resistive to care.	{F 677}	Assistants providing ADL care including toileting and nail care- 6 residents per week x 5 weeks, then 3 residents per week x 4 weeks. Data will be summarized and presented to the facility Quality Assurance Performance Improvement Committee meeting monthly x 2 months by the Administrator and or Acting DON. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised to ensure continued compliance. The Administrator and or Acting Director of Nursing are responsible for implementing and maintaining the acceptable plan of correction. Corrective action will be completed on or before 4/1/2019.	

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{F 677}	Continued From page 2 Interview with NA #4 on 3/4/19 at 4:13 pm revealed she had noticed the brown substance underneath Resident #13's nails which prompted her to clean and cut them. NA#4 further indicated that she had worked with Resident #13 yesterday (3/3/19) but she did not recall seeing any brown or black substance underneath her nails. Interview with the Nurse Consultant on 3/7/19 at 1:24 pm revealed it was communicated to her that Resident #13 would rectally dig. She further revealed it was her expectation that residents received nail care and hands cleaned prior to dining. Interview with NA#2 on 3/7/19 at 1:28 pm revealed she had provided Resident #13 with a bath but did not complete nail care. She stated she wasn't looking at her nails to identify any substance underneath Resident #13 nails. Interview with the facility Administrator on 3/7/19 at 4:28PM revealed it was her expectation that residents received assistance with nail care and have hands cleaned prior to dining. She further indicated it was important to ensure hand hygiene was completed due to Resident #13 being observed to rectally dig.	{F 677}		

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F 000	INITIAL COMMENTS On 03/07/19, the Division of Health Service Regulation, Nursing Home Licensure and Certification conducted an onsite revisit. While some deficiencies cited on the complaint investigation on 12/20/2018 were corrected effective 01/18/19, the facility remains out of compliance.	F 000		
{F 677} SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to provide nail care for 1 of 5 dependent residents (Resident #13). The findings included: Resident #13 was admitted to the facility on 12/17/18 with a diagnosis that included Hemiplegia and Hemiparesis following cerebral infraction affecting left non-dominate side, adult failure to thrive, moderate protein-calorie malnutrition, Parkinson's disease, Alzheimer's disease and gastro-esophageal reflux disease. The most recent Minimum Data Set (MDS) assessment dated 12/17/18 revealed Resident #13 required limited assistance with eating, extensive assistance with personal hygiene and was moderately cognitively impaired. Review of Resident #13 care plan revealed no care plan for Activities of Daily living.	{F 677}	Nail Care was provided on resident # 13 by the C.N.A on 3/4/19 resident has pruritus which causes resident #13 to scratch consistently. 2. All Residents have the potential to be affected by the alleged deficient practice; the Administrator completed an audit on 03/08/2019-3/15/2019 to ensure that no other resident was affected. 3. Certified nursing assistants received in-service on Performing nail care on 3/8/19 and How to perform nail care on 3/31/2019 on residents requiring assistance. The education will continue to be included in subsequent new-hire orientation. 4.The Administrator and or designee will continue to randomly checked compliance	4/1/19

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{F 000}	INITIAL COMMENTS On 03/07/19, the Division of Health Service Regulation, Nursing Home Licensure and Certification conducted an onsite revisit. While some deficiencies cited on the complaint investigation on 10/25/18 and recited on 12/20/18 were corrected effective 01/18/19, the facility remains out of compliance.	{F 000}		
{F 677} SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to provide nail care for 1 of 5 dependent residents (Resident #13). The findings included: Resident #13 was admitted to the facility on 12/17/18 with a diagnosis that included Hemiplegia and Hemiparesis following cerebral infraction affecting left non-dominate side, adult failure to thrive, moderate protein-calorie malnutrition, Parkinson's disease, Alzheimer's disease and gastro-esophageal reflux disease. The most recent Minimum Data Set (MDS) assessment dated 12/17/18 revealed Resident #13 required limited assistance with eating, extensive assistance with personal hygiene and was moderately cognitively impaired. Review of Resident #13 care plan revealed no care plan for Activities of Daily living.	{F 677}	Nail Care was provided on resident # 13 by the C.N.A on 3/4/19 resident has pruritus which causes resident #13 to scratch consistently. 2. Residents that have pruritus have the potential to be affected by the alleged deficient practice; the Administrator completed an audit on 03/08/2019-3/15/2019 to ensure that no other resident was affected. 3. Certified nursing assistants received in-service on Performing nail care on 3/8/19 and How to perform nail care on 3/31/2019.on residents requiring assistance. The education will continue to be included in subsequent new-hire orientation. 4. The Nurses and Administrator will be responsible for this aspect of the plan of correction. The Administrator and or designee will randomly check compliance	4/1/19

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{F 677}	Continued From page 1 Observation on 3/3/19 at 12:57pm revealed resident to be in her room. During the observation a family member was present while resident meal tray was being set up. Staff member (name unknow) was observed to set up Resident #13's meal tray on the bedside table. The resident was observed to have a brown and black substance underneath the nails of her right hand. The brown substance was present while resident ate food items by hand. Interview with Resident #13's family member on 3/3/19 at 12:59pm revealed the substance underneath Resident #13's nails were most likely fecal matter because Resident #13 would rectally dig occasionally. She indicated Resident #13#s nails normally looked like that. Interview with Resident #13 on 3/3/19 at 1:05 pm revealed she was unaware of when her nails were last cleaned. Observation of Resident #13 on 3/3/19 at 3:51 pm revealed the resident to be seated in front of the nursing station covered with a blanket. The residents right hand could be observed clutching the top of the blanket. The fingernail of resident's right hand was observed to have brown matter. Observation of Resident #13 on 3/4/19 at 8:48 am revealed the resident to be eating breakfast in the main dining room. The fingernails of her right hand were observed to have a brown substance. Observation of Resident #13 on 3/4/19 at 4:11 pm revealed the resident to be receiving nail care by Nursing Assistant (NA) #4. Resident #13 was not resistive to care.	{F 677}	of Certified Nursing Assistants providing nail care- 6 residents per week x 4 weeks, then 3 residents per week x 4 weeks. The Plan of correction was reviewed in the daily stand up meeting with the Department Heads. The Plan of Correction monthly audit data will be reported by each auditor to subsequent monthly Quality Assurance Performance Committee for review, recommendations and updated as needed to ensure compliance. Corrective action will be completed on or before 4/1/2019.	

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{F 677}	Continued From page 2	{F 677}		

Interview with NA #4 on 3/4/19 at 4:13 pm revealed she had noticed the brown substance underneath

Resident #13's nails which prompted her to clean and cut them. NA#4 further indicated that she had worked with Resident #13 yesterday (3/3/19) but she did not recall seeing any brown or black substance underneath her nails.

Interview with the Nurse Consultant on 3/7/19 at 1:24 pm revealed it was communicated to her that Resident #13 would rectally dig. She further revealed it was her expectation that residents received nail care and hands cleaned prior to dining.

Interview with NA#2 on 3/7/19 at 1:28 pm revealed she had provided Resident #13 with a bath but did not complete nail care. She stated she wasn't looking at her nails to identify any substance underneath Resident #13 nails.

Interview with the facility Administrator on 3/7/19 at 4:28PM revealed it was her expectation that residents received assistance with nail care and have hands cleaned prior to dining. She further indicated it was important to ensure hand hygiene was completed due to Resident #13 being observed to rectally dig.