STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

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E 000	Initial Comments An unannounced Recertification survey was conducted on 3/11/19 through 3/15/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #QT1R11.	E 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups.	F 565		4/10/19

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

Electronically Signed | 04/08/2019

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F 565	Continued From page 1 §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews, the facility failed to resolve grievances that were reported by the Resident Council during meetings for four of eight months reviewed: September 2018, October 2018, December 2018 and March 2019. Findings included: The resident council meeting was conducted on 3/13/2019 at 10:42 AM with six residents actively participating in the meeting. An issue was discussed regarding resolution of grievances. In the meeting the residents stated grievances were not acted upon or resolved. The residents stated they had voiced their concerns about staff answering call bells timely for several months and nothing had been done. It was agreed among the residents attending this was a problem. A review of the facility policy titled Grievances: Healthcare Centers and noted effective 1/1/1997 and revised 3/25/2019 revealed the facility administrator is the grievance official and is responsible for overseeing the grievance process. The policy stated any staff can take a grievance, write it and give it to the administrator. The policy further stated the administrator will refer the grievance to the appropriate department for investigation. The responsible discipline will make prompt efforts to resolve the grievance.	F 565	This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction do not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the state and federal law. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents. IMMEDIATE CORRECTIVE ACTION Administrator discussed resident concerns related to answering call bells from Resident Council meeting of 3/6/2019 at Managers meeting on 3/8/19. Following the meeting Administrator went to each Nursing Station and informed staff of the issues and our expectations related to answering call bells and use of cell phones. SW provided In-Service to staff on 3/9/19 and 3/10/19 related to Resident Rights. Administrator reviewed survey deficiencies including follow up on Resident Counsel issues with	

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F 565	Continued From page 2 A review of the resident council meeting minutes for September 19, 2018 revealed, under the heading of Nursing, residents from several halls stated the call bell response time was slow. A review of the resident council meeting minutes for October 17, 2018 revealed resolutions from previous meeting were discussed. No further information was listed. Under the heading of Nursing, residents stated the call bell response time was slow. A review of the resident council meeting minutes for November 7, 2018 revealed resolutions from previous meeting were discussed. No further information was listed. There were no issues the residents complained about. A review of the December 7, 2018 resident council meeting minutes revealed resolutions from previous meeting were discussed. No further information was listed. Under the heading of Nursing: Long call bell times. Residents want to know the names of their Nursing Assistants (NAs). Both the January 4, 2019 and the February 11, 2019 resident council meeting minutes were reviewed and noted resolutions from previous meetings were discussed, and both had no further information. Both meeting minutes had no issues under the heading of Nursing. A review of the March 6, 2019 resident council meeting minutes revealed resolutions from previous meeting were discussed. No other information was listed. Under the heading of Nursing: NA call bell response times are very	F 565	Management Team on 3/18/19. Administrator assigned Managers to make unannounced visits on night shift to observe for compliance of cell phone usage and answering call lights timely and asked them to report back to team. Visits made on 3/28/19 and 3/29/19 on 2nd and 3rd shifts. Visits planned for 4/6/19 /and 4/7/19. Manager reported to team on 4/1/19 that expectations set on call bells being answered promptly and cell phone usage had been communicated to night staff. On 4/1/19 Manager reported back to team that there was marked improvement. On 3/18/19 Administrator reviewed with Activities Director the policies for Resident Council Meetings to include how to report concerns from Resident Council meetings. On 3/18/19 Administrator advised team to inform residents that any department head would be available upon request to meet with the Council to address concerns and/or answer questions. Administrator asked AD to report to residents that we are working on their concerns. 3/18/19 On 4/2/19 Administrator randomly interviewed residents to inquire if any improvement had been made in call response time, and all responses were positive. On 3/28/19 a QAPI meeting was held. Survey results were reviewed. Team discussed follow up on Resident Council concerns regarding improving call bell	

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F 565	Continued From page 3 long. NAs sit in the hallway chairs and play on their phones and do not pay attention to the call bells. A review of grievance logs from October 2018 until March 13, 2019 revealed no grievances listed from resident council. The facility policy stated the administrator would be responsible for follow up with the resident to determine the grievance has been resolved. The policy stated grievances should be resolved within three business days. On 3/15/2019 at 12:50 PM, in an interview, the Activity Director (AD) stated she took the minutes of the resident council meetings. The AD indicated she did not make other notations about the meetings, only what was in the meeting minutes. The AD noted she could not explain what resolutions from previous meetings were discussed. The AD stated she wrote grievances and took them to the Administrator. In an interview on 3/15/2019 at 1:10 PM, the Administrator stated she did not have any written grievances from the AD. The Administrator stated she expected the AD to fill out a grievance form. The Administrator stated her expectation was that grievances would be acted upon right away.	F 565	response time and cell phone usage by staff on duty. Disciplinary process to be utilized for non-compliance. Our goals are to eliminate staff using phones on duty and to reduce complaints. Staff meetings are scheduled to address survey issues to include call bell response time and use of personal phones while on duty. 4/8/19 and 4/9/19. METHODS TO IDENTIFY ANY OTHER RESIDENTS WHO MIGHT BE AFFECTED Alert and oriented residents will be identified by the initial assessment and Bims score of 15. Other alert and oriented residents who might be affected will be identified through the grievance procedure, Resident Council, Family Council, and interviews by staff, including the Administrator beginning 4/5/19 and ongoing. Additionally, all alert and oriented residents have the potential to be affected. To determine if any alert and oriented residents have call bell issues, patient halls will be audited weekly for six weeks for timeliness of response to the call bell to begin 4/29/19. Audits will then be done monthly for 4 months. The audit will include staff observing at nursing station for length of time of response, as well as interviews with alert and oriented residents on the hall being audited. Any non-compliance issues will be addressed as soon as possible with assigned staff. When	

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F 565	Continued From page 4	F 565		

appropriate responsible staff will enter the disciplinary process. Progress/lack of progress will be reviewed at monthly and quarterly QAPI.

SYSTEMIC CHANGES

Following each Resident Council Meeting the Activity Director will submit the minutes of the meeting to include completion of a Response form if any concerns arise from the meeting. The form will be forwarded to the appropriate department for appropriation action. Upon completion the form will be forwarded to the Administrator for review to ensure the problem has been addressed and satisfaction has been achieved. As of 4/4/19 Managers will be available to attend the Resident Council meeting upon their invitation. Ongoing

MONITORING PROCESS

Following each Resident Council meeting the Administrator will verbally inquire in a timely manner about the results of the meeting. The Administrator will review documentation via the minutes and response form to assure concerns are addressed within 3 days. 4/5/19 and ongoing
All concerns that come forth from the Resident Counsel will be reviewed at all monthly and quarterly QAPI meetings to analyze trends by subject, shift, assigned staff, location and resident until all concerns are resolved. Goals and approaches with time frames will be put in

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F 565	Continued From page 5	F 565	place and monitored for progress/lack of progress. 4/5/19 and ongoing until resolved.	
F 636 SS=E	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed	F 636		4/12/19

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F 636	Continued From page 6 on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete an admission Minimum Data Set (MDS) assessment within the required time frame for 5 of 31 sampled residents whose MDS assessments were reviewed (Resident #48, Resident #4, Resident #6, Resident #16 and Resident #17). Findings included: 1. A review of the medical record revealed Resident #48 was admitted 10/31/2018 with	F 636	IMMEDIATE CORRECTIVE ACTION Resident # 48 Comprehensive assessment was completed on 1/4/2019, Resident # 4 annual Comprehensive assessment was completed on 3/15/2019. Resident # 6 annual comprehensive assessment was completed on 3/15/2019. Resident # 16 annual comprehensive assessment was completed on 3/15/2019. Resident # 17 annual comprehensive assessment was completed on 11/19/18.	

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F 636	Continued From page 7 diagnoses that included Diabetes, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure and depression. The Admission Minimum Data Set (MDS) dated 11/14/2018 included information for Resident #48, but was not signed by the MDS Nurse as being completed until 1/4/2019. On 3/14/2019 at 10:30 AM the MDS nurse was interviewed and stated Resident #48 had an Admission MDS with an Assessment Review Date of 11/7/2018. The MDS nurse stated the Resident's admission MDS assessment was not completed and signed until 1/4/2019. The MDS nurse indicated two new staff had been hired, but were still being trained. The MDS nurse stated other staff had been helping out to get the MDS work caught up. On 3/15/2019 at 1:40 PM in an interview, the Administrator stated there is a problem with getting the MDS work caught up and her expectation is that the MDS will be caught up and done timely. 2. Resident #4 was admitted to the facility on 7/28/17. Her cumulative diagnoses included a history of heart failure, peripheral vascular disease, and severe protein-calorie malnutrition. A review of Resident #4 ' s Minimum Data Set (MDS) assessments included quarterly assessments with Assessment Reference Dates (ARDs) of 4/17/18, 7/3/18, and 10/1/18. No additional MDS assessments were completed after 10/1/18.	F 636	METHODS TO IDENTIFY ANY OTHER RESIDENTS WHO MIGHT BE AFFECTED All residents have the potential to be affected. The OBRA calendar was printed on 3/15/19, by the MDS nurses, to identify late admission and annual MDS assessments OBRA calendar is printed, by the MDS Coordinator, daily to identify late admission and annual MDS assessments for all residents. A MDS team member will print the OBRA calendar and review it with the interdisciplinary team daily in morning meeting. All current admission and annual assessments will be submitted per RAI guidelines and reviewed weekly by MDS coordinator. Admissions and Annual Comprehensive assessments that are already late will be scheduled so that a combined total of five assessments are completed each week until all are completed. Admissions that are coming due, we will complete no later than 14 days from the date of facility Admission. Annual Comprehensive assessments that are coming due, we will complete no later than 366 days/+ 13 days from prior OBRA comprehensive assessment	

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F 636	Continued From page 8 An interview was conducted on 3/13/19 at 3:23 PM with MDS Nurse #1. During the interview, the MDS nurse was asked when Resident #4 ' s next MDS assessment was due to be completed. The MDS nurse reported an annual assessment with an ARD date of 12/17/18 had not been completed as scheduled. A follow-up interview was conducted on 3/14/19 at 8:45 AM with MDS Nurse #1, accompanied by the MDS Corporate Consultant. During the interview, a request was made for clarification of the 12/17/18 ARD due date previously provided. The corporate consultant reported the resident's annual MDS was scheduled with an ARD date of 12/17/18. She stated the resident had a significant change MDS completed on 2/1/18, which changed the scheduling of the assessments. The corporate consultant confirmed that at the time of this review (3/14/19), the annual MDS for Resident #4 had not completed and was overdue. An interview was conducted on 3/15/19 at 11:05 AM with the facility's Director of Nursing (DON). During the interview, the DON reported her expectation was for MDS assessments to be completed on a timely basis. 3. Resident #6 was admitted to the facility on 9/8/17 with re-entry on 2/21/18. Her cumulative diagnoses included a history of cerebral vascular accident (CVA or stroke) and hemiplegia/hemiparesis (a paralysis or weakness on one side of the body). A review of Resident #6 ' s Minimum Data Set (MDS) assessments included a significant change MDS with an Assessment Reference	F 636	SYSTEMIC CHANGES The Clinical Reimbursement Consultant will complete by 4/10/2019 covering RAI guidelines regarding timeliness of MDS assessments per discipline specific section for the: Dietary Manager, MDS Coordinators, Social Work, Activities Director and Skin Integrity Nurse on the requirements of completing Admission and Annual Comprehensive MDS assessments within the specified timeframes. The Assessment calendar will be provided to and reviewed by the Interdisciplinary Team in morning meeting daily to ensure Admission assessments are completed no later than 14 days from date of facility admission and no later than 366 days/+ 13 days from ARD for Annuals from previous Annual assessment completion date. All admissions and annual assessments, that are already late, will be scheduled so that a combined total of five assessments are completed until all late assessment are complete. MONITORING PROCESS The Administrator and or the Director of Health Services in collaboration with MDS nurses will review the due Admission and Annual Assessments 5 days a week for 4 weeks, then weekly for 2 months and then quarterly thereafter until compliance has been maintained for 3 quarters. The	

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Date (ARD) of 2/28/18. Quarterly MDS assessments with dates of 5/14/18, 6/13/18, 7/20/18 and 10/8/18 were also completed. No additional MDS assessments were completed after 10/8/18. An annual MDS assessment with an ARD of 1/2/19 was noted as "open" and was not completed in the facility ' s electronic MDS system.

An interview was conducted on 3/13/19 at 3:25 PM with MDS Nurse #1. During the interview, the MDS nurse confirmed Resident #6 ' s annual MDS assessment dated 1/2/19 had not been completed. Upon further inquiry, the nurse reported the annual MDS should have been closed on 1/16/19 and transmitted on 2/6/19. The MDS nurse acknowledged this MDS assessment was overdue.

An interview was conducted on 3/15/19 at 11:05 AM with the facility's Director of Nursing (DON). During the interview, the DON reported her expectation was for MDS assessments to be completed on a timely basis.

4. Resident #16 was admitted to the facility on 7/12/16. His cumulative diagnoses included dementia and Parkinson ' s disease.

A review of Resident #16 ' s Minimum Data Set (MDS) assessments included an annual MDS with an Assessment Reference Date (ARD) of 2/13/18. Quarterly MDS assessments with dates of 4/30/18, 7/16/18, 10/10/18, and 11/1/18 were also completed. No additional MDS assessments were completed after 11/1/18.

An interview was conducted on 3/14/19 at 8:45 AM with MDS Nurse #1 and the MDS Corporate

findings will be reported to the Quality Assurance Performance Improvement Committee monthly for 3 months and quarterly thereafter until compliance for 3 quarters has been achieved.

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Consultant. During the interview, Resident #16's MDS assessments were reviewed. The nurses confirmed the quarterly MDS with an ARD of 11/1/18 was the last MDS completed for this resident. The next planned MDS would have been an annual MDS scheduled for 1/3/19, which was not completed. Upon further inquiry, the Corporate Consultant reported Resident #16 ' s next annual MDS would have required an ARD date due by 2/13/19. As of the date of the review (3/14/19), the annual MDS had not been completed. The nurses acknowledged this annual MDS assessment was overdue.

An interview was conducted on 3/15/19 at 11:05 AM with the facility's Director of Nursing (DON). During the interview, the DON reported her expectation was for MDS assessments to be completed on a timely basis.

5. Resident #17 was admitted to the facility on 11/7/16. Her cumulative diagnoses included diabetes and hypertension.

A review of Resident #17 ' s Minimum Data Set (MDS) assessments revealed her most recent assessment was an annual MDS with an Assessment Reference Date (ARD) of 10/15/18. This assessment was signed by the Registered Nurse as having been completed on 11/19/18.

An interview was conducted on 3/14/19 at 8:45 AM with MDS Nurse #1 and the MDS Corporate Consultant. During the interview, Resident #17's annual MDS assessment dated 10/15/18 was discussed. Upon review, the Corporate Consultant reported this MDS was not signed off as having been completed within the required time frame.

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F 636	Continued From page 11 An interview was conducted on 3/15/19 at 11:05 AM with the facility's Director of Nursing (DON). During the interview, the DON reported her expectation was for MDS assessments to be completed on a timely basis.	F 636		
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete quarterly assessments within the required time frame for 3 of 31 residents reviewed for timeliness of quarterly assessments. (Residents #17, #32 and #48). The findings included: 1. Resident #17 was admitted to the facility on 11/7/16. Her cumulative diagnoses included diabetes and hypertension. A review of Resident #17 ' s Minimum Data Set (MDS) assessments revealed her most recent assessment was an annual MDS with an Assessment Reference Date (ARD) of 10/15/18. No additional MDS assessments were completed after 10/15/18. An interview was conducted on 3/14/19 at 8:45 AM with MDS Nurse #1 and the MDS Corporate Consultant. During the interview, Resident #17's	F 638	IMMEDIATE CORRECTIVE ACTION Resident # 17 Quarterly assessment was completed on 3/15/2019. Resident # 32 Quarterly assessment was completed on 3/15/2019. Resident # 48 Quarterly assessment was completed on 3/15/2019. METHODS TO IDENTIFY ANY OTHER RESIDENTS WHO MIGHT BE AFFECTED All residents have the potential to be affected. The OBRA calendar was printed on 3/15/19, by the MDS nurses, to identify late admission and annual MDS assessments OBRA calendar is printed, by the MDS Coordinator, daily to identify late admission and annual MDS assessments for all residents. A MDS team member will print the OBRA calendar and review it with the	4/12/19

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F 638	Continued From page 12 MDS assessments were reviewed. The MDS nurse confirmed no additional MDS assessments had been completed since 10/15/18. She reported the next planned MDS for Resident #17 would have been a quarterly MDS with an ARD date due by 1/11/19. MDS Nurse #1 and the MDS Corporate Consultant acknowledged this quarterly MDS assessment was overdue. An interview was conducted on 3/15/19 at 11:05 AM with the facility's Director of Nursing (DON). During the interview, the DON reported her expectation was for MDS assessments to be completed on a timely basis. 2. A review of the medical record revealed Resident #32 was admitted to the facility on 10/26/2018 with diagnoses that included Sepsis, Diabetes, anxiety and Chronic Pain Syndrome. A review of MDS assessments for Resident #32 revealed the last completed MDS assessment was an admission MDS completed on 11/9/2018. A quarterly MDS assessment was not completed since Resident #32's admission MDS. A care plan was developed. On 3/14/2019 at 10:30 AM the MDS nurse was interviewed and stated Resident #32's quarterly MDS was opened on 1/18/2019 and had not been completed. The MDS nurse stated the MDS work was not current and she was getting some help from other qualified staff, and had hired 2 new staff for MDS, but they had not completed training. On 3/15/2019 at 1:40 PM, the Administrator stated she was aware there was a problem with the MDS and her expectation was the quarterly MDS assessments would be done timely.	F 638	interdisciplinary team daily in morning meeting. All current admission and annual assessments will be submitted per RAI guidelines and reviewed weekly by MDS coordinator. Quarterly assessments that are already late will be scheduled so that five assessments are completed each week until all is done. Quarterly assessments that are coming due, we will complete no later than 92 days from prior OBRA assessment. SYSTEMIC CHANGES The Clinical Reimbursement Consultant will provide education by 4/10/19 covering RAI guidelines MDS assessments per disciplines specific section for the Dietary Manager, MDS Coordinator, Social Worker, Activities Director and Skin Integrity Nurse on the requirements of completing quarterly MDS assessments within 92 days of the previous assessment as required. The Assessment calendar will be provided to and reviewed by the Interdisciplinary Team in morning meeting. Quarterly assessments that are coming due, we will complete no later than 92 days from prior OBRA assessment. MONITORING PROCESS	

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F 638	Continued From page 13 3. A review of the medical record revealed Resident #48 was admitted to the facility on 10/31/2018 with cumulative diagnoses of Diabetes, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease and depression. The Admission MDS dated 1/4/2019 noted Resident #48 was severely impaired for cognition and needed extensive assistance for all Activities of Daily Living, with the physical assistance of one person. A care plan was developed. A review of the quarterly MDS for Resident #48 dated 2/5/2019 revealed it was not completed. On 3/14/2019 at 10:30 AM, the MDS nurse was interviewed and stated the quarterly MDS for Resident #48 was started on 2/5/2019 and was not completed. The MDS nurse stated she was behind on the MDS work and had been receiving assistance from other staff on the weekend, but was still behind. The MDS nurse stated two other MDS staff had been hired, but were still in training. On 3/15/2019 at 1:40 PM, the Administrator stated she was aware there was a problem with the MDS and her expectation was the quarterly MDS assessments would be done timely.	F 638	The Administrator and or the Director of Health Services in collaboration with MDS nurses will review the due Quarterly Assessments 5 days a week for 4 weeks, then weekly for 2 months and then quarterly thereafter until compliance has been maintained for 3 quarters. The findings will be reported to the Quality Assurance Performance Improvement Committee monthly for 3 months and quarterly thereafter until compliance for 3 quarters has been achieved.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §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	F 656		4/10/19

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F 656	Continued From page 14 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 section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to develop a comprehensive care plan for one of two residents reviewed for urinary catheters (Resident #132). Findings included:	F 656	IMMEDIATE CORRECTIVE ACTION Resident # 132 care plan was reviewed and revised on 3/15/2019. METHODS TO IDENTIFY ANY OTHER RESIDENTS WHO MIGHT BE AFFECTED	

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F 656	Continued From page 15 A review of the medical record revealed Resident #132 was admitted with diagnoses of stroke, hemiplegia, Chronic Obstructive Pulmonary Disease and Coronary Artery Disease. The Annual Minimum Data Set (MDS) dated 8/23/2018 noted Resident #132 to be severely impaired for cognition and needed limited to extensive assistance for all Activities of Daily Living with the physical help of one person. The Care Area Assessment noted a focus of urinary incontinence. A review of progress notes dated 2/9/2019, revealed Resident #132 had a surgical procedure scheduled in February and the catheter was in place. The procedure was not done and the catheter was left in place. An observation of Resident #132's catheter was made on 3/12/2019. The catheter was patent and draining clear yellow urine. In an interview on 3/14/2019 at 1:57 PM, Nurse #1 stated Resident #132 had the catheter since 2/3/2019 and was scheduled for a urology appointment. The Corporate MDS nurse stated, on 3/14/2019 at 2:00 PM, there was no care plan for the catheter. On 3/15/2019 at 1:40 PM, in an interview, the Administrator stated her expectation was the care plans would be done timely and be complete with a focus and working toward goals.	F 656	The Director of Nursing, Assistant Director of Nursing, Case Mix Director and Nurse Managers reviewed residents with appliances to validate a care plan was in place for the resident□s with appliance. SYSTEMIC CHANGES The Director of Nursing, Clinical Competency Coordinator and/or Case Mic Director began education with the Interdisciplinary Team and Licensed staff regarding updating care plans to reflect new appliances placed on/within residents. This education has been added to the new hire orientation for Licensed Nurses. Licensed nurses not education by 4/10/2019 will compete education prior to beginning their scheduled shift or be removed from the schedule until the education is completed. The Case Mix Director, Director of Nursing and/or Nurse Manager will review Residents with appliances and validate the appliances have been care planned. weekly for 4 weeks then monthly for 3 months then quarrel thereafter. MONITORING PROCESS The Case Mix and/or Director of Nursing will track and trend the appliance review and present the analysis to the Quality Assurance and Performance Improvement Committee monthly until three months of compliance is sustained then quarterly thereafter.	
F 760	Residents are Free of Significant Med Errors	F 760		4/10/19

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F 760 SS=D	Continued From page 16 CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, physician assistant (PA) and staff interviews, the facility failed to apply and remove lidocaine patches (patches containing an analgesic medication to manage localized pain) in accordance with the physician's orders for 1 of 1 resident (Resident #159) who was observed to have medicated patches applied to her skin. The findings included: Resident #159 was admitted to the facility on 2/19/16 with re-entry from a hospital on 5/16/16. The resident's cumulative diagnoses included chronic obstructive pulmonary disease (COPD) and foot pain. The resident was receiving Hospice Care at the time of the review. A review of Resident #159's most recent quarterly Minimum Data Set (MDS) assessment dated 2/13/19 indicated the resident had moderately impaired cognitive skills for daily decision making. The resident required extensive assistance from staff for all of her Activities of Daily Living (ADLs), with the exception of requiring supervision for eating and being totally dependent on staff for locomotion. Section J of the MDS revealed the resident received scheduled medications for occasional, moderate pain. A review of the resident's Care Plans included the following area of focus, in part:	F 760	IMMEDIATE CORRECTIVE ACTION The Licensed Nurse removed the Lidoderm patch from Resident # 159 on 3/15/19. The Licensed Nurse observed Resident # 159 skin condition which identified intact skin condition and completed vital signs which were within the normal limits for the Resident. The Physician Assistant was notified on 3/15/2019 with no new orders. The Director of Nursing - Educated the night shift nurse□s on removal of patch and documentation on 3/15/19, then validated the patch was removed on 3/16/19, and continued education with all Licensed staff. METHODS TO IDENTIFY ANY OTHER RESIDENTS WHO MIGHT BE AFFECTED On 3/15/2019 the Director of Nursing, Assistant Director of Nursing, Clinical Competency Coordinator, and/or Nurse Manager reviewed all residents with Lidoderm patches to ensure the patches were removed and documentation on the medication administration was completed. The initial review identified 21 out of 139 residents with Lidoderm / asper-cream	

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F 760	Continued From page 17 --3/17/16 (last reviewed on 2/12/19) Resident is at risk for increased pain due to her disease process and is receiving hospice services. A review of the resident's current medications included 5% lidocaine patches (initiated on 11/7/16). The physician orders provided instructions to apply a patch every day at 8:00 AM on the resident's left hip, left knee, and lower back. The patches were to be removed every day at 8:00 PM and to remain off for 12 hours. According to the product manufacturer, up to 3 lidocaine patches may be applied in a single application. Patch(es) may remain in place for up to 12 hours in any 24-hour period. A review of Resident #159's medical record included her March 2019 Medication Administration Record (MAR). The MAR included documentation which indicated lidocaine patches were applied to the resident on 3/10/19 at 8:00 AM, removed on 3/10/19 at 8:00 PM, applied on 3/11/19 at 8:00 AM, removed on 3/11/19 at 8:00 PM, applied on 3/12/19 at 8:00 AM, and removed on 3/12/19 at 8:00 PM. A medication administration observation was conducted on 3/13/19 at 7:50 AM as Nurse #1 administered medications to Resident #159. Prior to applying lidocaine patches to the resident, the nurse removed a lidocaine patch from the resident's back (which was dated 3/10/19), a patch from her shoulder (dated 3/11/19), a patch from her left hip (dated 3/11/19), and a patch from her left knee (dated 3/11/19). An interview was conducted on 3/13/19 at 9:47 AM with the facility's Physician's Assistant (PA) who helped provide care for Resident #159.	F 760	patches, 21 of 21 reviewed identified correct application / removal and documentation of patch. SYSTEMIC CHANGES On 3/15/19, education began for the licensed nursing staff currently employed on removing Lidoderm patches, as ordered, and how to properly document the placement and removal of patch by the Director of Health Services, Clinical Competency Coordinator, Nurse Navigator, and nurse management team. This education has also been added to the general orientation for newly hired nurses. 100% of all scheduled employee will be educated by April 10th, 2019. Staff members who have not completed the education will be educated prior to their next scheduled shift and/or be removed from the schedule until education in completed. The Director of Nursing, Assistant Director of Nursing and/or Nurse Manager is validating 100% of the residents with a Lidoderm patch for application and removal documentation and visual removal of the Lidoderm patch for 7 days, with proper documentation of same, daily for 7 days, then 50% of residents with Lidoderm patches weekly for 4 weeks, then 25% of residents with Lidoderm patches monthly for 3 months then quarterly thereafter.	

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During the interview, the PA was informed of the observations made earlier that morning when lidocaine patches dated 3/10/19 and 3/11/19 were found to be applied to the resident. When asked, the PA stated she would expect the lidocaine patches to be applied to the resident for 12 hours, then removed, and for the patches to remain off for 12 hours in accordance with the orders.

An interview was conducted on 3/13/19 at 10:04 AM with Nurse #1. During the interview, concern was expressed regarding the lidocaine patches dated 3/10/19 and 3/11/19 found to be remaining on Resident #159 during the medication administration observation. When asked, the nurse confirmed the dates of the patches she removed prior to placing new lidocaine patches on Resident #159. The nurse stated she did not work on 3/11/19 or 3/12/19 so could not provide any pertinent information as to why they were still applied to the resident. Nurse #1 stated, "There was no excuse" for the patches to be left on the resident because the instructions for the application and removal of the patches were on the resident's MAR. A follow-up interview was conducted with Nurse #1 on 3/15/19 at 8:20 AM. During the interview, the nurse again confirmed the locations and dates of the lidocaine patches found on Resident #159 during the 3/13/19 morning medication administration observation.

A telephone interview was conducted on 3/14/19 at 4:52 PM with Nurse #2. Nurse #2 was identified by her initials on Resident #159's March 2019 MAR as having removed the lidocaine patches for the resident on 3/10/19 at 8:00 PM. The nurse reported she worked at the facility on an "as needed" basis and last worked 3/10/19 on 2nd shift (3:00 PM - 11:00 PM). During the

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interview, the nurse stated she recalled working with Resident #159 the evening of 3/10/19. The nurse recalled that when she went to remove the three lidocaine patches from the resident, she only saw and removed one patch. Nurse #2 reported she had a hard time locating where the patches had been placed because she did not routinely work with this resident. She stated she told the nursing assistant (NA) working with the resident to let her know if more lidocaine patches were found when the resident got ready for bed so the nurse could remove any patches remaining on her. The nurse reported she was not alerted to any more patches being seen on the resident.

An interview was conducted on 3/14/19 at 1:49 PM with Nurse #3. Nurse #3 was identified by her initials on Resident #159's March 2019 MAR as having applied lidocaine patches for the resident on 3/11/19 at 8:00 AM. During the interview, the nurse confirmed her initials on the MAR for the morning of 3/11/19 indicated she applied lidocaine patches to this resident. The nurse stated she specifically recalled when she went to apply the patches, there was one patch on her left knee and one on her left hip still applied to the resident. She reported these patches apparently had not been removed the evening of 3/10/19. Nurse #3 stated she removed those patches and checked to see if there were any other lidocaine patches on the resident; she did not locate any others prior to applying the new patches to the resident that morning.

A telephone interview was conducted on 3/14/19 at 1:13 PM with Nurse #4. Nurse #4 was identified by her initials on Resident #159's March

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2019 MAR as having removed the lidocaine patches for the resident on 3/11/19 at 8:00 PM. Upon inquiry, the nurse stated the removal of Resident #159's lidocaine patches may possibly have gotten missed. "...I thought I might have removed it (the patches) and always try to make sure; but, might have missed taking them off."

An interview was conducted on 3/13/19 at 4:02 PM with Nurse #5. Nurse #5 was identified by her initials on Resident #159's March 2019 MAR as having applied the lidocaine patches for the resident on 3/12/19 at 8:00 AM. During the interview, the nurse confirmed her initials on the MAR indicated she applied lidocaine patches on Resident #159 the morning of 3/12/19. Upon inquiry, the nurse recalled telling the resident she would come back to apply the patches and she didn't. Nurse #5 confirmed she did not apply the patches to Resident #159 on the morning of 3/12/19 as ordered.

A telephone interview was conducted on 3/15/19 at 10:16 AM with Nurse #6. Nurse #6 was identified by her initials on Resident #159 ' s March 2019 MAR as having removed the lidocaine patches for the resident on 3/12/19 at 8:00 PM. During the interview, the nurse stated she did not specifically recall whether or not she removed the lidocaine patches from Resident #159 on the evening of 3/12/19.

An interview was conducted on 3/15/19 at 11:05 AM with the facility's Director of Nursing (DON). During the interview, the DON reported she had been made aware of the concerns related to Resident #159's lidocaine patches. The DON stated her expectation was for the nurses to follow the physician's orders as to when and

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F 760	Continued From page 21 where a patch was to be applied and when the patch needed to be removed. When asked if she felt leaving a lidocaine patch on for more than 12 hours was a significant medication concern, the DON stated, "Oh definitely."	F 760		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;	F 842		4/10/19

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F 842	Continued From page 22 (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility failed to accurately document the application and removal of lidocaine patches (patches containing an	F 842	IMMEDIATE CORRECTIVE ACTION The Licensed Nurse removed the Lidoderm patch from Resident # 159 on 3/15/19. The Licensed Nurse observed	

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F 842	Continued From page 23 analgesic medication to manage localized pain) on the Medication Administration Record (MAR) for 1 of 1 resident (Resident #159) reviewed who was observed to have medicated patches applied to the skin. The findings included: Resident #159 was admitted to the facility on 2/19/16 with re-entry on 5/16/16 from a hospital. The resident's cumulative diagnoses included chronic obstructive pulmonary disease (COPD) and foot pain. A review of Resident #159's most recent quarterly Minimum Data Set (MDS) assessment dated 2/13/19 indicated the resident had moderately impaired cognitive skills for daily decision making. The resident required extensive assistance from staff for all of her Activities of Daily Living (ADLs), with the exception of requiring supervision for eating and being totally dependent on staff for locomotion. Section J of the MDS revealed the resident received scheduled medications for occasional, moderate pain. A review of the resident ' s current medications included 5% lidocaine patches (initiated on 11/7/16). The physician orders included instructions to apply a patch every day at 8:00 AM on the resident's left hip, left knee, and lower back. The patches were to be removed every day at 8:00 PM and to remain off for 12 hours. According to the product manufacturer, up to 3 lidocaine patches may be applied in a single application. Patch(es) may remain in place for up to 12 hours in any 24-hour period. A review of Resident #159's medical record	F 842	Resident # 159 skin condition which identified intact skin condition and completed vital signs which were within the normal limits for the Resident. The Physician Assistant was notified on 3/15/2019 with no new orders. The Director of Nursing - Educated the night shift nurse□s on removal of patch and documentation on 3/15/19, then validated the patch was removed on 3/16/19, and continued education with all Licensed staff. METHODS TO IDENTIFY ANY OTHER RESIDENTS WHO MIGHT BE AFFECTED On 3/15/2019 the Director of Nursing, Assistant Director of Nursing, Clinical Competency Coordinator, and/or Nurse Manager reviewed all residents with Lidoderm patches to ensure the patches were removed and documentation on the medication administration was completed. The initial review identified 21 out of 139 residents with Lidoderm / asper-cream patches, 21 of 21 reviewed identified correct application / removal and documentation of patch. SYSTEMIC CHANGES On 3/15/19, education began for the licensed nursing staff currently employed on removing Lidoderm patches, as ordered, and how to properly document the placement and removal of patch by the Director of Health Services, Clinical Competency Coordinator, Nurse	

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F 842	Continued From page 24 included her March 2019 Medication Administration Record (MAR). The MAR included documentation which indicated lidocaine patches were applied to the resident on 3/10/19 at 8:00 AM, removed on 3/10/19 at 8:00 PM, applied on 3/11/19 at 8:00 AM, removed on 3/11/19 at 8:00 PM, applied on 3/12/19 at 8:00 AM, and removed on 3/12/19 at 8:00 PM. A medication administration observation was conducted on 3/13/19 at 7:50 AM as Nurse #1 administered medications to Resident #159. Prior to applying lidocaine patches to the resident, the nurse removed a lidocaine patch from the resident's back (which was dated 3/10/19), a patch from her shoulder (dated 3/11/19), a patch from her left hip (dated 3/11/19), and a patch from her left knee (dated 3/11/19). An interview was conducted on 3/13/19 at 10:04 AM with Nurse #1. During the interview, concern was expressed regarding the lidocaine patches dated 3/10/19 and 3/11/19 found to be remaining on Resident #159 during the medication administration observation. When asked, the nurse confirmed the dates of the patches she removed prior to placing new lidocaine patches on Resident #159. The nurse stated she did not work on 3/11/19 or 3/12/19. A telephone interview was conducted on 3/14/19 at 4:52 PM with Nurse #2. Nurse #2 was identified by her initials on Resident #159's March 2019 MAR as having removed the lidocaine patches for the resident on 3/10/19 at 8:00 PM. The nurse reported she worked at the facility on an "as needed" basis and last worked 3/10/19 on 2nd shift (3:00 PM - 11:00 PM). During the interview, the nurse stated she recalled working	F 842	Navigator, and nurse management team. This education has also been added to the general orientation for newly hired nurses. 100% of all scheduled employee will be educated by April 10th, 2019. Staff members who have not completed the education will be educated prior to their next scheduled shift and/or be removed from the schedule until education in completed. The Director of Nursing, Assistant Director of Nursing and/or Nurse Manager is validating 100% of the residents with a Lidoderm patch for application and removal documentation and visual removal of the Lidoderm patch for 7 days, with proper documentation of same, daily for 7 days, then 50% of residents with Lidoderm patches weekly for 4 weeks, then 25% of residents with Lidoderm patches monthly for 3 months then quarterly thereafter. MONITORING PROCESS The Director of Nursing will track and trend the results of the Lidoderm patch and documentation review and present the analysis to the Quality Assurance/Performance Improvement Committee monthly until three months of continued compliance is noted.	

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with Resident #159 the evening of 3/10/19. The nurse recalled that when she went to remove the three lidocaine patches from the resident, she only saw and removed one patch. The nurse reported she initialed the MAR to indicate the task had been completed because she removed the one patch she had seen.

An interview was conducted on 3/14/19 at 1:49 PM with Nurse #3. Nurse #3 was identified by her initials on Resident #159's March 2019 MAR as having applied lidocaine patches for the resident on 3/11/19 at 8:00 AM. During the interview, the nurse confirmed her initials on the MAR from the morning of 3/11/19 indicated she applied lidocaine patches to this resident. The nurse stated she specifically recalled when she went to apply the patches, there was one patch on her left knee and one on her left hip still applied to the resident. She reported these patches apparently had not been removed the evening of 3/10/19. Nurse #3 stated she removed those patches and checked to see if there were any other lidocaine patches on the resident; she did not locate any others prior to applying the new patches to the resident that morning.

A telephone interview was conducted on 3/14/19 at 1:13 PM with Nurse #4. Nurse #4 was identified by her initials on Resident #159's March 2019 MAR as having removed the lidocaine patches for the resident on 3/11/19 at 8:00 PM. Upon inquiry, the nurse stated the removal of Resident #159's lidocaine patches may possibly have gotten missed. Nurse #4 reported after she completed medication administration for the entire hall, she would usually "flip through" the MARs to be sure everything she had

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administered or done was initialed. The nurse stated, "I should have left it (the MAR) blank and checked it (the lidocaine patches). I thought I might have removed it (the patches) and always try to make sure; but, might have missed taking them off." When asked, the nurse reported that if something was initialed on the MAR, it typically meant the medication was administered or the task was completed.

An interview was conducted on 3/13/19 at 4:02 PM with Nurse #5. Nurse #5 was identified by her initials on Resident #159's March 2019 MAR as having applied the lidocaine patches for the resident on 3/12/19 at 8:00 AM. During the interview, the nurse confirmed her initials on the MAR indicated she applied lidocaine patches on Resident #159 the morning of 3/12/19. Upon inquiry, the nurse recalled telling the resident she would come back to apply the patches and she didn't. Nurse #5 confirmed she did not apply the patches to Resident #159 on the morning of 3/12/19 as ordered.

A telephone interview was conducted on 3/15/19 at 10:16 AM with Nurse #6. Nurse #6 was identified by her initials on Resident #159's March 2019 MAR as having removed the lidocaine patches for the resident on 3/12/19 at 8:00 PM. During the interview, the nurse stated she did not specifically recall whether or not she removed the lidocaine patches from Resident #159 on the evening of 3/12/19. Nurse #6 reported she typically initialed the MAR to indicate she read the order, then would go into the resident's room to administer the medications (or in this case, remove the lidocaine patches).

An interview was conducted on 3/15/19 at 11:05

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F 842	Continued From page 27 AM with the facility's Director of Nursing (DON). During the interview, the DON reported she had been made aware of the concerns related to Resident #159's lidocaine patches. When asked about the accuracy of MDS documentation, the DON stated she would expect nurses to initial the MAR right after a task was completed or a medication was administered.	F 842		