STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345183	A. BUILDING _____ B. WING _____	C 05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE & REHAB	430 BROOKWOOD AVENUE NE CONCORD, NC 28025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification survey was conducted on 05/19/2019 through 05/23/2019. The facility was found in compliance with the requirement CFR 483.73. Emergency Preparedness. Event ID # PVF911.	E 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F 550		6/20/19

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

Electronically Signed | 06/17/2019

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F 550	Continued From page 1 resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews the facility failed to treat a resident in a dignified manner, by allowing the resident to wear socks which had the name of another resident on them, for 1 of 3 residents reviewed for dignity (Resident #85). The findings included: Resident #85 was admitted on 5/24/18 and the resident's cumulative diagnoses included: Multiple Sclerosis (MS), sickle cell disease, chronic pain, diabetes, depression, bipolar disorder, schizophrenia, and generalized weakness. Review of Resident #85's most recent Minimum Data Set (MDS) revealed an annual comprehensive assessment with an Assessment Reference Date (ARD) of 4/25/19. The resident was coded as having been cognitively intact. The resident was coded as having had no hallucinations or delusions and the resident was coded as having had 1-2 occurrences through the assessment period of verbal behavioral symptoms directed toward others (examples, threatening others, screaming at others, cursing	F 550	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth by the survey team, or of any violation of regulation. It is solely created to demonstrate our good faith attempt to continue to provide a quality of life for all of our residents. 1) Measure for affected resident: Resident # 85 was provided her own socks and clothing to wear as of 6/20/19. 2) Measure for residents with potential to be affected: An audit of 100% of residents belongings was completed as of 6/20/19 as a part of the Customer Service Action Rounds (Members include Unit Coordinator #1, Unit Coordinator #2, Social Services, Social Services Assistant, Dietary Manager, Dietary Manager Assistant, Admissions Coordinator, Business Office Manager, Human Resources Manager, Activities Director, and Maintenance	

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F 550	Continued From page 2 at others) which did not significantly impact the resident's health, significantly interfere with other residents, nor significantly interfere with the resident's participation in activities. An observation was conducted on 5/22/19 at 9:52 AM of Resident #85's dressing change. Upon completion of the dressing change by the Wound Nurse (WN), Nursing Assistant (NA) #7 was observed to have placed white socks on the resident which had the initial of the first name and last name of Resident #6 written on each sock in very visible black letters on the foot of each sock. The NA completed putting the socks on the resident and cover the resident's feet with the bed linens. An observation was conducted on 5/22/19 at 10:00 AM in conjunction with an interview with NA #7. NA #7 pulled back the bed linens of Resident #85 and observed Resident #85 had socks on which belonged to Resident #7. The NA stated she had not seen the markings on the resident's socks indicating the socks belonged to another resident. The NA stated she had removed the same socks from the resident prior to the dressing change and had not noticed Resident #7's name on the socks. The NA stated she had not put the socks on the resident this morning and stated the socks had been put on the resident prior to her shift. The NA stated she would remove the socks immediately and she would not have put the socks on the resident had she known the socks had belonged to another resident. The NA further stated she would return the socks to laundry, so they could be washed and returned to Resident #7. An interview conducted on 5/22/19 at	F 550	Director) to ensure that each resident has only clothing that belongs to them. There were 3 identified residents with clothing labeled for other residents. These were removed and sent to laundry for re-washing and will be re-labeled if donated or returned to their owners if current residents. 3) Systemic Change: Laundry staff will check residents clothing prior to placement in a residents room to ensure that only clothing that belongs to that resident is placed there utilizing a system of resident census and a sorting procedure to place residents clothing behind a tab with the room number on it. If a resident donates clothing, the clothing will be re-labeled prior to allowing another resident to use them. Certified Nursing Assistants will check resident□s clothing prior to dressing them to ensure that it belongs to that resident. Nursing Staff and Laundry staff will be educated by the Director of Nursing, the Assistant Director of Nursing or the Administrator regarding each resident□s right to a dignified existence and the importance of wearing their own clothing as of 6/20/19. Staff not available for training will not be allowed to work until training is completed. Newly hired Nursing or Laundry staff will be educated regarding each resident□s right to a dignified existence and the	

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F 550	Continued From page 3	F 550		

approximately 10:00 AM with the WN revealed she was not aware Resident #85 had been wearing or was wearing socks from another resident. She stated had she been aware or observed the socks belonged to another resident she would have stopped the NA from applying the socks to the resident.

During an interview conducted on 5/22/19 at approximately 10:00 AM with Resident #85 she stated emphatically she did not want to wear socks which belonged to another resident. The resident stated she had her own clothes she would wear. The resident further stated an NA had put the socks on her the evening before, on 5/21/19. The resident stated if she would have known the socks had another resident's name on them she would not have let the NA put them on her.

An interview and observation were conducted with the Laundry Aide (LA) on 5/22/19 at 10:05 AM. The LA stated she had two laundry baskets for resident socks which were not marked with a resident's name. She stated one laundry basked had matching pairs of socks while the other basket had individual socks without matching mates. The LA pointed to two laundry baskets with multiple socks in each basket. The LA stated if an NA needed socks for a resident, the NA would come to the laundry room and get a pair of socks out of the basket with matched pairs of socks. The LA stated socks with a resident's name should not be placed into either of the laundry baskets which were used for socks without a resident's name. The LA stated she had worked the evening before and had remembered an NA coming to the laundry room and getting a pair of socks out of the matched

importance of wearing their own clothing at the time of hire.

4) Monitoring:

The Customer Service Action Rounds committee(Members include Unit Coordinator #1, Unit Coordinator #2, Social Services, Social Services Assistant, Dietary Manager, Dietary Manager Assistant, Admissions Coordinator, Business Office Manager, Human Resources Manager, Activities Director, and Maintenance Director)will audit 5 resident rooms per week, Monday through Friday, x one month and then 5 resident rooms per month x 11 months. Audits will be completed on the Customer Service Action Rounds form which has been modified to include this area.
Should others clothing be found in a resident's room, it will be removed, rewashed and returned to the correct resident and reflected on the Customer Service Action Rounds form.

The Administrator will compile a report on the findings of these audits and present them to the Quality Assurance and Performance Improvement committee monthly x one year.

The Quality Assurance and Performance Improvement committee will make changes to the plan as necessary.

Effective 6/20/19, the facility Administrator and the Director of Nursing will be ultimately responsible for the

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F 550	Continued From page 4 pair unnamed socks basket. An interview was conducted with the Housekeeping/Laundry Manager (HLM) on 5/22/19 at 10:23 AM. The HLM stated she would work on developing a better system which would minimize the chance of a resident receiving another resident's socks. The HLM stated the goal of the facility laundry was for residents to receive their clothing and for residents not to receive clothing which belonged to another resident. During an interview conducted with the Administrator on 5/23/19 at 1:24 PM she stated it was her expectation for each resident to have their own clothes to respect a resident's dignity.	F 550	implementation of this plan of correction to ensure the facility attains and maintains substantial compliance.	
F 567 SS=D	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in	F 567		6/20/19

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F 567	Continued From page 5 an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to provide residents access to their personal funds after the facility's banking hours for 1 of 2 residents reviewed (Resident #33) for personal funds. Findings included: Resident #33 was originally admitted to the facility on 2/17/17 and was most recently readmitted on 1/5/19. Resident #33's cumulative list of diagnoses included: Chronic Obstructive Pulmonary Disease (COPD), cellulitis (a form of tissue infection), and generalized weakness. A review of the Minimum Data Set (MDS) assessments revealed the most recent MDS	F 567	1) Measure for affected residents: Resident # 33 was informed of new process for availability of funds beginning on 6/20/19. Resident # 12 discharged to the hospital prior to notification of this process. He will be informed as of 6/20/19 pending readmission to the facility of the new procedure for accessing resident trust funds. 2)Measure for residents with potential to be affected: The Business Office Manager completed an audit of Resident Trust Accounts as of	

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F 567	Continued From page 6 assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 3/31/19. The resident was coded as having been cognitively intact. During an interview conducted on 5/19/19 at 10:16 AM Resident #33 stated he was unable to withdraw money from his Resident Trust Fund (RTF) account after 4:30 PM through the week or at all on the weekends. During an observation conducted on 5/19/19 (Sunday) at 12:00 PM Resident #12 was observed at the front desk and the weekend receptionist told the resident there were no banking hours on the weekends. An interview with the Weekend Receptionist (WR) and observation were conducted on 5/19/19 at 12:23 PM. The WR stated the residents of the facility were unable to get money from their RTF over the weekend because there was no one at the facility they could get their money from. The WR stated banking hours were Monday through Friday, 8:30 AM to 4:30 PM. The WR then pointed to a sign posted on the wall at the reception area which proclaimed banking hours were Monday through Friday, 8:30 AM to 4:30 PM. An interview was conducted on 5/22/19 at 12:24 PM with the Business Office Manager (BOM). The BOM stated the banking hours were posted at the reception area and stated residents could have access to their money in the RTF from 9:00 AM to 5:00 PM. The BOM stated there were times he was at the facility after 5:00 PM and if a resident wanted money after that he would be able to provide the resident with money from the	F 567	6/20/19 utilizing the Resident Trust Fund Reconciliation form to determine those with potential to be affected, no other residents were identified as being affected by this practice. At the time of the audit, residents who frequently withdraw money were informed of the new process for access to funds 24 hours, 7 days per week and that the funds are located on the A side cart. Signs were posted at the front lobby area/Business Office, one at eye level for wheelchair dependent residents, informing them of availability of funds and where they are located. 3) Systemic Change: Effective 6/20/19 Resident funds will be available during normal business hours through the Business Office. After hours, weekend and holidays, funds will be available on the Nursing Cart for A side. A sign was posted as of 6/20/19 at the Business office informing residents of the availability of funds including the availability on nights, holidays and weekends. A letter will be sent out with the facility Quarterly statements which will be delivered in July 2019, informing residents and responsible parties of the availability of funds. The Business Office Manager, Nurses and receptionists were educated by the	

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F 567	Continued From page 7 RTF. The BOM stated the residents of the facility had access to their money in their RTF pretty much whenever they wanted it. The BOM stated on weekends there was a small amount of cash available, in a lock box, in a file cabinet, in the BOM's office. The BOM stated the Charge Nurse would have had a master key and would be able to access his office and the lock box. He stated he had not printed out a balance sheet which would detail each resident's RTF balance for the Charge Nurse to make sure a resident had funds available to withdraw from the RTF. The BOM stated he was relatively new and had started recently and he had planned to put into place a way for residents to be able to access money from their RTF through the weekend and non-banking hours. The BOM stated no residents had come to him and expressed dissatisfaction with not being able to access money from their RTF during non-banking hours. The BOM stated it was his expectation for residents to have access to money from their RTF as the regulation stated. During an interview conducted on 5/23/19 at approximately 6:45 PM the Administrator stated it was her expectation for the residents of the facility to be able to access money from their RTF as per the federal regulations.	F 567	Director of Nursing, The Assistant Director of Nursing or the Administrator regarding the availability of funds and the importance of making them available to residents as of 6/20/19. Staff not available for training will not be allowed to work until they receive the training. Newly hired Business Office Staff, Nurses and receptionists will be educated regarding the availability of funds and disbursement of money after hours at the time of hire. 4)Monitoring: The Business Office Manager will audit the availability of money daily and replenish it as needed, Monday through Friday for one week, then weekly, Monday through Friday x 3 weeks. These audits will then be performed monthly x 11 months. The auditing tool that will be utilized will be the Resident Trust Fund availability form. The Business Office Manager will compile a report on the findings of these audits and present them to the Quality Assurance and Performance Improvement committee monthly x one year. The Quality Assurance and Performance Improvement committee will make changes to the plan as necessary. Effective 6/20/19, the facility Administrator	

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F 567	Continued From page 8	F 567	and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction to ensure the facility attains and maintains substantial compliance.	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting	F 584		6/20/19

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F 584	Continued From page 9 levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on resident interviews, staff interviews and observations the facility failed to maintain a safe, clean, comfortable, homelike environment: (1) maintain 3 of 3 clean spa/shower rooms (spa/shower rooms A, B and C), (2) clean fecal matter off the bathroom floor of 1 of 20 resident bathrooms reviewed (Room # 133-2), (3) maintain toilet bowls in resident bathrooms clean and free of brownish red stains in 2 of 20 resident bathrooms (Room # 220 and Room # 221), (4) clean trash, dirt and debris off bedside floor mats, under beds and on the floors 6 of 20 resident rooms (Rooms # 209-2, 216-1, 219- 2, 227 -2, 229-2 and Room # 230-2), (5) maintain 1 of 37 call light cords free of cracks and exposed interior insulation (Room # 219-2), (6) cleaned the walls and Packaged Terminal Air Conditioners (PTACs) of dried liquid spots of 2 of 20 rooms reviewed (Room # 209 and Room # 230), (7) maintain 1 of 20 PTAC unit covers with a secure mounted cover to prevent exposure of internal workings (Room # 209), (8) clean the frame, wheel rims and base of 1 of 1 wheel chair observed (Room # 126 - 1). Fndings included: 1. Spa/shower room A was observed on	F 584	1) Measure for affected Residents: Spa room A was cleaned as of 6/20/19 to include the following: Black mat was removed All gloves found on the floor were discarded Garbage can was placed in the Spa The rusted light fixture was replaced Light bulb was replaced Ceramic soap holder was cleaned The used bar of soap was discarded The trash can under the sink was emptied and a liner placed in it. The metal shower head was repaired and cleaned The metal hanger has been discarded The tub spa was cleaned The cabinet was discarded The hair brush and hair combs were discarded The hair shampoo and conditioner was discarded The hair dryer has been labeled and placed in a bag The yellow adult briefs were discarded The toilet was flushed and cleaned	

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F 584	Continued From page 10 05/19/2019 at 1:51 PM. The entry door was closed, but not locked. On entrance in to the shower room immediately to the right is the restroom. A black rubber mat was crumbled on the floor in the left corner of the restroom. There were 3 to 4 used gloves scattered on the restroom floor around the toilet. No garbage can was visible. On the right-side wall outside of the restroom the sink was observed with a rusted light fixture mounted over the sink and only 1 light bulb was lit. The light fixture cover was clouded over with dust and a dried white milky substance that resembled old dried soap film. There was a ceramic soap holder attached to the wall above the sink to the right was coated with a dusty brown substance and a dried white substance that appeared to be dried soap. A bar of used dried soap was observed in the rim of the sink. A trash can under the sink on the right side contained no trash can liner and over flowed with paper towels and gloves that spilled on to the floor. Around the corner to the right was the shower stall. The shower stall had 2 shower heads installed one of which had a shower nozzle on an extendable white shower hose. The second shower head was metal and attached to the wall. The metal shower head had no cover on it and the inside of the metal shower head was observed with a dark black substance that appeared to resemble mold around the inside surfaces of the metal shower head. On the metal shower head that extended from the hall a metal hanger was wrapped around the pipe that extended from the wall and the hanger hook was sticking out as if it may have been used a hook to hold linen items in the shower stall. Straight in front of the shower stall facing the rear of the shower stall was a large tub spa which had a large rusted brown colored spot down the inside	F 584	The toilet bowl plunger was placed in a plastic bag, the original plastic bag was discarded Spa/Shower room B was cleaned as of 6/20/19 to include the following: The light was repaired in the toilet area The 'rusty colored' light fixture was cleaned and repaired The soap dish was cleaned The open, used soap was discarded The pipes under the sink have been cleaned The shower head was cleaned and repaired The spa/tub was cleaned, the mat was discarded The shelving unit door was removed Spa/Shower room C was cleaned as of 6/20/19 to include the following: The light fixture was replaced Light bulbs were placed in new fixture The spa/tub was cleaned The yellow foam cushion was discarded The hair brush was discarded The hook was discarded The two shower chairs were cleaned including the back and legs The towels were sent to laundry for laundering Room #133-2 fecal matter was cleaned from the floor as of 6/20/19, The sheets were changed, the plastic container was discarded, the dirty clothing was sent to	

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F 584	Continued From page 11 of the tub spa that was dried and measured approximately 6 inches in length. The tub spa had a drain plug in place over the drain and the plug was covered with dust and dirt. To the rear left of the tub spa in the left back corner of the spa/shower room was a white coated metal shelf attached to the wall and directly under the shelf was a greenish black colored plastic cabinet that has a chair propped against the 2 doors of the plastic shelf. When the chair was moved, the 2 doors of the plastic cabinet opened freely. The top of the plastic shelf unit contained one used hair brush with hair in the bristles. The hair brush along with 2 hair combs also observed on the top outside of the plastic shelf Inside the plastic cabinet there was one shelf and the base which was also used as a shelf or storage area. On the inside shelf an opened, unlabeled bottle of hair shampoo and hair conditioner were observed. The shelf also contained a dark brown colored hair dryer that was not labelled. The bottom shelf or base of the plastic shelf contained two yellow colored adult briefs bunched up. On 05/20/2019 at 11:03 AM an observation of spa/shower room B revealed that the entrance door was locked and had to be unlocked and opened by a staff member. On the right side of the spa/shower room was the toilet (rest room area). There was no working light in the toilet area when the light switch was turned to the on position. On the right wall past the toilet area the sink was observed with a rusty colored light fixture over the sink. The light fixture was secured to the wall on the left side only the right side was not attached to the wall and was tilted down toward the sink. The light fixture was coated with a white milky colored hard substance. Mounted above the sink under the light fixture was a metal	F 584	laundry. Drawers in closet were put in place and the room was organized by the Housekeeping Manager as of 6/20/19. Room #220 and #221 toilets were replaced as of 6/20/19 Room #209-2,216-1, 219-2, 227-2, 229-2 and 230-2 under beds between mattresses and bed rails and bedside mats and underneath floor mats and under and behind all furnishings were cleaned as well as the PTAC unit for 209 as of 6/20/19 by the Housekeeping Manager. Call light cord for 219-2 was replaced as of 6/20/19 Walls and Package Terminal Air Conditioners (PTACs) for rooms 209 and 230 were cleaned as of 6/20/19 Package Terminal Air Conditioners cover (PTAC) in 209 was repaired and secured as of 6/20/19 Wheelchair for resident in 126-1 was cleaned as of 6/20/19 2)Measure for residents with potential to be affected: All residents have the potential to be affected An audit of 100% of residents rooms and common areas was completed as of 6/20/19 as a part of the Customer Service Action Rounds (Members include Unit	

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F 584	Continued From page 12 colored soap dish that was rust colored and coated with a white milky dried soapy film. There was an open used dried bar of soar on the edge of the sink. The white pipes under the sink were covered with a brown colored dusty dirt layer. Around a corner to the right was the shower stall. The metal shower head protruding from the tile wall in the shower stall area was rusty and not attached securely to the wall. Facing out of the shower stall toward the back wall of the spa/shower room was a spa tub. The inside of the spa tub contained a dark brown mat that was dusty, stained and had dried dirt spots on it. To the left behind the spa tub in the back-left corner of spa/shower room B was a dark greenish black plastic shelf unit. The shelf unit had a right door which was attached to the cabinet and was closed the left side door was resting between the shelf unit and the wall. On 05/20/2019 at 11:13 AM an observation of spa/shower room C revealed the entrance door was locked and required staff to unlock the door with the code. On the right-hand wall facing the rear of the room over the sink was a rusted, dirt and dust covered light fixture which was also covered with a dry milky white substance and only one of the two light bulbs were lit. toward the rear of the spa/ shower room was a spa tub that had dark brown rust colored stains scattered along the sides inside the tub. The inside of the spa tub also contained a square yellow foam shaped cushion, a hair brush covered with dust and hair which was not labelled and a metal hook with two exposed screws attached to the hook. Facing the entrance door of spa/shower room C two shower chairs were observed. One chair was made of a white plastic and had two dirt stained towels on the chair seat, the back of the chair behind the	F 584	Coordinator #1, Unit Coordinator #2, Social Services, Social Services Assistant, Dietary Manager, Dietary Manager Assistant, Admissions Coordinator, Business Office Manager, Human Resources Manager, Activities Director, and Maintenance Director) to ensure that each resident room is clean and homelike. An audit of 100% of common areas was conducted as of 6/20/19 by the Administrator, The Housekeeping Director or the Maintenance Director. 3) Systemic Change: Effective 6/20/19 each room and common area will be cleaned thoroughly each day by housekeeping staff. Each resident room and common area will be on a schedule to ensure a routine cleaning. 100% of housekeeping staff members have been educated as of 6/20/19 regarding the mandate to thoroughly clean resident rooms and common areas daily. Staff not available for training will not be allowed to work until training is complete. All newly hired housekeeping staff will be educated at the time of hire on the mandate to keep all resident rooms and common areas clean. 4) Monitoring: The Customer Service Action Rounds (Members include Unit Coordinator #1,	

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F 584	Continued From page 13 seat back had cut out indentations in the plastic that were covered with a dark reddish brown colored substance and the same substance was observed along the base of the chair and was heavier where the plastic pieces of the base connected to one another. Spa/ shower room C also had a second shower chair constructed of white PVC (Poly Vinyl Chloride) pipes as the chair base and had a dark green mesh seat and chair back. The white PVC pipes along the base of the chair were observed with a dark red brown colored substance coating the PVC pipe connection spots along the base of the chair. On 05/20/2019 at 11:27 AM spa/shower room A's entrance door was unlocked and freely opened. The restroom or toilet area to the right of the inside of the spa shower room was observed with the toilet bowl filled to the rim with toilet paper, feces and urine. A toilet bowl plunger was observed next to the toilet bowl and it was uncovered and rested on a plastic bag. On 05/21/2019 at 9:37 AM an interview was conducted with housekeeper # 1. Housekeeper #1 revealed that she cleaned the spa/shower rooms every day that she worked at about 11:00AM. Housekeeper # 1 revealed that in each of the three spa shower rooms she spray cleaned all shower chairs, cleaned the toilets and sinks, replenished the paper towels and toilet paper, emptied the trash cans. Housekeeper # 1 revealed that the rooms were kept locked and required a code to unlock the doors and that during the week, the shower team nurse assistants (NAs) kept the rooms clean as well. On 05/23/2019 at 9:19 AM the facility administrator was interviewed. The administrator	F 584	Unit Coordinator #2, Social Services, Social Services Assistant, Dietary Manager, Dietary Manager Assistant, Admissions Coordinator, Business Office Manager, Human Resources Manager, Activities Director, and Maintenance Director)will audit 5 resident rooms per week x one week, Monday through Friday to ensure a clean and homelike environment. The audits will continue with 3 resident rooms x 3 weeks, Monday through Friday and then 5 resident rooms per month x 11 months. The Administrator will compile a report for the Quality Assurance and Performance Improvement (QAPI) committee monthly x one year. The Quality Assurance and Performance Improvement committee will make changes to the plan as necessary. Effective 6/20/19, the facility Administrator and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction to ensure the facility attains and maintains substantial compliance.	

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revealed that she was aware of many of the spa/shower room concerns and the expectation was that all areas of the facility be clean and homelike, and all fixtures and equipment be maintained in good repair.

On 05/23/2019 at 10:35 AM an interview was conducted with shower team NA #1 and shower team NA # 2. The shower team NAs revealed that the shower rooms were cleaned daily by the housekeeper when the shower rooms were not in use this included all equipment in the shower rooms. The shower team NAs revealed that spa/shower room A entrance door had not locked in a long time and that the nurses knew it, but they had not been told when that door would be fixed to lock and unlock with a code as the B and C spa/shower rooms do.

2. Resident #88 was admitted to the facility 11/26/2018 and readmitted 12/7/2018 with diagnoses to include diabetes, depression and hypertension. The admission Minimum Data Set (MDS) assessment dated 12/14/2018 assessed Resident #88 to be cognitively intact.

Room 133's bathroom was observed on 5/19/2019 at 12:24 PM. A soiled brief was on the floor and a brown stain, appearing to be fecal matter was on the tile floor.

Room 133's bathroom was observed on 5/19/2019 at 2:06 PM. The soiled incontinence brief was removed from the floor, but the brown stain remained on the tiled floor.

An observation of Room 133's bathroom was made on 5/20/2019 at 9:17 AM. The brown stain remained on the tiled floor.

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Room 133's bathroom was observed on 5/21/2019 at 9:01 AM and the brown stain remained on the floor.

A final observation of Room 133's bathroom was conducted on 5/21/2019 at 10:59 AM. The floor was clean, and no stain was noted on the floor.

Resident #88 was interviewed on 5/21/2019 at 10:59 AM and he reported he lived in Room 133 and the stain was fecal matter from an incontinence episode. He further reported he had cleaned up the solid waste the best he could, but the floor was not mopped until the morning of 5/21/2019.

Nursing assistant (NA) #4 was interviewed on 5/22/2019 at 10:31 AM and she reported if she found fecal matter on the floor, she would clean up the solid waste and use antibacterial wipe to clean the floor and then notify housekeeping the floor needed to be disinfected.

NA #2 was interviewed on 5/22/2019 at 10:55 AM and she reported she cleaned up incontinence accidents with a disinfectant wipe and then called housekeeping to disinfect the floor.

NA #5 was interviewed on 5/22/2019 at 11:10 AM and she reported she used disinfectant wipes to clean up incontinence accidents and called housekeeping to mop.

Housekeeper #2 was interviewed on 5/22/2019 at 2:35 PM and she reported each room was mopped each day, including the bathroom.

NA #6 was interviewed on 5/22/2019 at 3:20 PM and she reported she used a sanitizing wipe to

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clean up accidents and because housekeeping was not available on evening shift, she would not call housekeeping.

The Administrator was interviewed on 5/23/2019 at 9:19 AM and she reported she expected the facility to be clean and homelike.

6. An observation conducted on 5/19/19 at 10:06 AM revealed a fall mat on each side of the bed for bed 2 in room 219 to have debris (dirt, dust, hair, crumbs, etc ...) and have been sticky.

An observation conducted on 5/19/19 at 10:18 AM revealed trash and debris on the floor under the bed for bed 2 in room 227.

An observation conducted on 5/19/19 at 11:13 AM revealed the following for bed 1 in room 229: 20-30 fish shaped crackers on the floor under the resident's bed, debris, crumbs under the fall mat next to the bed, and tartar sauce in a 2-3-ounce container on the floor.

An observation conducted on 5/19/19 at 11:22 AM revealed a fall mat on each side of the bed for bed 1 in room 216 to have had debris on top of and under them.

An observation conducted on 5/19/19 at 11:29 AM revealed the following in room 230 at bed 2: A 4 ounce ice cream container, a 4 ounce nutrition shake, a brown liquid (which had dried) on the floor where the over the bed table had rolled through the liquid and there were foot prints in the liquid, 3 packs of condiments behind the bed on the floor, multiple dried spots from liquid on the floor behind the bed, a white paper bag in the wall protection bump rail behind the bed, approximately 9 packets of a butter or margarine

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product behind the bedside night stand on the floor, dried liquid spots on the wall next to the bedside night stand, and dried liquid spots on the Packaged Terminal Air Conditioning (PTAC) unit.

An observation conducted on 5/19/19 at 3:28 PM revealed the toilet in the bathroom for room 220 had brownish red stains on the inside rim of the bowl extending downward from toilet rim flush water holes.

The following was observed during a round conducted on 5/22/19 at 4:27 PM: Room 209 had a stuffed animal, piece of brief, straws, spoons, toward the window side of the bed on the floor, the PTAC unit cover was observed to have been loose from its mounts exposing some of the internal workings of the unit, room 229 had a shoe, dirt, debris under the bed and there was various debris under the fall mat to the right of the bed, room 230 had a white paper bag in the wall protection bump rail behind the bed, approximately 9 packets of a butter or margarine product behind the bedside night stand on the floor, dried liquid spots on the wall next to the bedside night stand, a napkin and a paper straw wrapper under the bed and dried liquid spots on the Packaged Terminal Air Conditioning (PTAC) unit, the bathroom in room 221 had brownish red stains on the inside rim of the bowl extending downward from toilet rim flush water holes, room 216 had debris both on top of and under the floor mats on both sides of the bed, and room 219 at bed 2 had floor mats on each side of the bed which were observed to have had had debris both on top of and under the mat as well as having been sticky between the surface of the mat and the floor when picked up.

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The Administrator was interviewed on 5/23/2019 at 9:19 AM and she reported she expected the facility to be clean and homelike.

An interview was conducted with Housekeeper (HSK) #2 on 5/23/19 at 2:35 PM. The HSK stated her room cleaning routine included wiping down the furniture in the room, sweeping and mopping the floor, and cleaning the bathroom. She stated she sometimes picked up the floor mats and cleaned underneath them but usually just swept off the top of the mats. The HSK stated she did not know if the mats got washed, she hadn't seen the mats get washed, but she was pretty sure they washed the mats down.

Observations were conducted in conjunction with an interview with the District Housekeeping Manager (DHM) during a round on 5/23/19 at 2:49 PM. The toilets in the bathroom for rooms 220 and 221 were observed to have had brownish red stains on the inside rim of the bowl extending downward from the toilet rim flush water holes. The DHM stated the HSK had been trying to get the stains out of the toilets but he felt as the toilets may need to be replaced. The DHM stated daily cleaning was to include sweeping and mopping both on and under after having observed mats with debris both on and under in room 219 and he stated the mat did not look clean. An observation of room 230 revealed a white paper bag in the wall protection bump rail behind the bed, approximately 9 packets of a butter or margarine product behind the bedside night stand on the floor, dried liquid spots on the wall next to the bedside night stand, dried liquid spots on the Packaged Terminal Air Conditioning (PTAC) unit, 2 plastic knives/debris in between the mattress and the footboard. The DHM stated

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each room was deep cleaned once every 30 days, but the items observed in the room should have been addressed during daily cleaning and during deep cleaning furniture would be pulled out from the walls and that area would have been cleaned. The DHM arranged the room to be cleaned and the identified areas addressed. Room 209 had a stuffed animal, piece of brief, straws, spoons, toward the window side of the bed on the floor, the PTAC unit cover was observed to have been loose from its mounts exposing some of the internal workings of the unit. The DHM stated the loose cover for the PTAC unit should have been reported to maintenance. He stated there was not a work order system in place to document work orders, but there was maintenance log at the nurses' station where maintenance concerns may be documented.

Observations were conducted in conjunction with an interview with the Maintenance Director (MD) during a round on 5/23/19 at 4:35 PM. The PTAC unit cover was observed to have been loose from its mounts exposing some of the internal workings of the unit. The MD stated he was unaware the PTAC unit cover had come loose. The MD put the PTAC unit cover back into place and moments later, it fell loose and went back to previously observed position exposing portions of the internal workings of the unit. The MD stated he would have liked to have received a work order regarding the loose PTAC cover.

7. An observation conducted on 5/19/19 at 10:33 AM revealed the call light cord for bed 2 in room 219 to have had the outside insulation broken in two places exposing the black and red insulation

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of the low voltage wires.

An observation made during a round conducted on 5/22/19 at 10:33 AM revealed the call light cord for bed 2 in room 219 to have had the outside insulation broken in two places exposing the black and red insulation of the low voltage wires.

The Administrator was interviewed on 5/23/2019 at 9:19 AM and she reported she expected all facility equipment to be in good repair.

Observations were conducted in conjunction with an interview with the Maintenance Director (MD) during a round on 5/23/19 at 4:35 PM. The call light cord for bed 2 in room 219 to have had the outside insulation broken in two places exposing the black and red insulation of the low voltage wires. The MD stated the call light needed to be replaced and he had them in stock. The MD stated he was unaware the internal wires from the call light cord were exposed.

8. An observation conducted on 5/19/19 at 2:16 PM revealed the resident in room 126-1 was in the dining room with a wheelchair which had dirt, debris, hair, and dust build up on the frame of the wheelchair at the base of the frame and on the rims.

An observation conducted on 5/21/19 at 8:30 AM revealed the resident in room 126-1 was in the activities room with a wheelchair which had dirt, debris, hair, and dust build up on the frame of the wheelchair at the base of the frame and on the rims.

Observations conducted during a round

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conducted on 5/22/19 at 4:27 PM revealed the resident from 126-1 was in the dining room with a wheelchair which had dirt, debris, hair, and dust build up on the frame of the wheelchair at the base of the frame and on the rims.

During an interview conducted during a round on 5/23/19 at 2:49 PM with the District Housekeeping Manager (DHM) he stated every wheelchair in the facility was cleaned every 30 days and as needed. In addition, the DHM stated any housekeeper could clean a wheelchair on the spot if it is observed to have been needed to be cleaned. An observation conducted during the round revealed the resident from 126-1 was in the dining room with a wheelchair which had dirt, debris, hair, and dust build up on the frame of the wheelchair at the base of the frame and on the rims. The DHM stated the resident's wheelchair was dirty and it needed to have been cleaned.

During an interview conducted with the Administrator on 5/23/19 at 4:56 PM she stated normally the housekeeping department does manage cleaning the wheelchairs, but the Director of Nursing had initiated a move for the cleaning of resident wheelchairs by the nursing staff. She stated the nursing staff had not started to clean the resident wheelchairs, but the plan was to have a nursing staff member come in during third shift to clean resident wheelchairs. The Administrator further stated it was difficult to get the wheelchair of Resident #91 to get it cleaned. She stated the resident from 126-1 frequently traveled throughout the facility and would sometimes sleep in her wheelchair. The Administrator stated it was her expectation for resident wheelchairs to be clean.

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F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business	F 585		6/20/19

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address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement

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F 585	Continued From page 24 as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interviews the facility failed to record a grievance for 1 of 3 residents reviewed for misappropriation of personal property (Resident #85). Findings include: Resident #85 was admitted on 5/24/18 and the resident's cumulative diagnoses included: Multiple Sclerosis (MS), sickle cell disease, chronic pain, diabetes, depression, bipolar disorder, schizophrenia, and generalized weakness. Review of Resident #85's most recent Minimum Data Set (MDS) revealed an annual comprehensive assessment with an Assessment Reference Date (ARD) of 4/25/19. The resident was coded as having been cognitively intact. The resident was coded as having had no	F 585	1) Measure for affected residents: Resident # 85 has had her grievance recorded and resolved as of 6/20/19. 2)Measure for residents with potential to be affected: An interview of 100% of interviewable residents was completed as a part of the Customer Service Action Rounds (Members include Unit Coordinator #1, Unit Coordinator #2, Social Services, Social Services Assistant, Dietary Manager, Dietary Manager Assistant, Admissions Coordinator, Business Office Manager, Human Resources Manager, Activities Director, and Maintenance Director) as of 6/20/19 to ensure that each resident's concerns/grievances have been recorded and resolved. There were no	

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hallucinations or delusions and the resident was coded as having had 1-2 occurrences through the assessment period of verbal behavioral symptoms directed toward others (examples, threatening others, screaming at others, cursing at others) which did not significantly impact the resident's health, significantly interfere with other residents, nor significantly interfere with the resident's participation in activities.

An interview was conducted with Resident #85 on 5/19/19 at 12:36 PM. The resident alleged she had missing clothing. The resident stated she had reported it back in March and did not feel as though the facility had investigated the missing clothing. The resident stated she had not seen several articles of clothing since they had been sent to laundry back in March.

A review completed of the resident grievance logs from 12/1/19 through 5/19/19 revealed no grievances alleging missing clothing from Resident #85.

An interview was conducted with the Laundry Aide (LA) on 5/22/19 at 10:05 AM. The LA stated she did not fill out a grievance form if she was informed of a resident who was missing clothing.

An interview was conducted with the Housekeeping/Laundry Manager (HLM) on 5/22/19 at 10:23 AM. The HLM stated the Housekeeping/Laundry staff members did not fill out grievances. She stated nurses filled out grievances and the grievances were then distributed to the responsible departments during the morning meeting by the head nurse.

An interview was conducted on 5/23/19 at 12:20

identified grievances that had not been reported or resolved.

3)Systemic Change:

Concern/Grievance forms will be located at each nurses station for easy access for staff and residents effective 6/20/19.

All staff have been re-educated as of 6/20/19 by the Director of Nursing, The Assistant Director of Nursing or the Administrator regarding the mandate to record and report all resident grievances as part as the Abuse and Neglect Prohibition Plan. Each staff member was re-educated on the mandate to protect residents in situations where they may be at risk for harm. Staff not available for education will not be allowed to work until the education is complete.

All newly hired staff will be educated regarding grievance reporting at the time of hire.

4)Monitoring:

The Customer Service Action Rounds committee (Members include Unit Coordinator #1, Unit Coordinator #2, Social Services, Social Services Assistant, Dietary Manager, Dietary Manager Assistant, Admissions Coordinator, Business Office Manager, Human Resources Manager, Activities Director, and Maintenance Director)will interview 5 interviewable residents per week x one week beginning on 6/20/19 to determine if

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F 585	Continued From page 26 PM with Nursing Assistant (NA) #5. The NA stated Resident #85 had told her a lot of her clothes were missing and she had not received them back from laundry. The NA stated she had not filled out a grievance nor report the missing clothes to anyone because she felt like the missing clothing had been mentioned a couple of months ago. The NA stated she had not filled out a grievance form in a while and she would complete a grievance form if someone had asked her to fill out a grievance. An interview as conducted on 5/23/19 at 12:25 PM with NA #6. The NA stated she had not filled out a grievance form for a resident since she had been working at the facility, about 6 months. She said had a resident whose family washed the resident's clothes. The NA stated the family would complain sometimes about clothing having been missing. The NA stated despite the resident having been family laundry (meaning the resident's family washed the clothes and not the facility) the resident's clothes had been sent to the facility laundry. The NA stated she had been able to go to the laundry department and locate the resident's clothing and return it to the family. An interview was conducted with the Administrator on 5/23/19 at 1:24 PM. The Administrator stated she had not received a grievance nor was she aware of Resident #85 having alleged she was missing any clothing. The Administrator stated it was her expectation that any staff member of the facility, including the Housekeeping/Laundry staff, to be able to complete a grievance form when a resident or a family member expresses a grievance. The Administrator further stated it was her expectation for a staff member to complete a grievance form	F 585	there are other unreported grievances. These audits will then be conducted with 2 residents per week x 3 weeks, then 2 residents per month x 11 months. The Administrator will compile a report to the Quality Assurance and Performance Improvement (QAPI) committee one time monthly x one year. The Quality Assurance and Performance Improvement committee will make changes to the plan as necessary. Effective 6/20/19, the facility Administrator and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction to ensure the facility attains and maintains substantial compliance.	

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F 585	Continued From page 27 for a resident who alleges missing clothing when the items cannot be located, or the resident/family expresses further dissatisfaction regarding the alleged missing articles of clothing.	F 585		
F 636 SS=D	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	F 636		6/20/19

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F 636	Continued From page 28 regarding the additional assessment performed 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 staff interviews and medical record review the facility failed to complete the Minimum Data Set (MDS) assessment for 2 residents (Resident #1 and Resident #2) that had been discharged from the facility. Findings included: 1.Resident #1 was admitted to the facility on 7-26-10 with multiple diagnosis that included dementia, anxiety and depression. Resident #1	F 636	1) Measure for affected residents: The discharge MDS (Minimum Data Set) assessment for Resident #1 and Resident #2 was completed by the facility MDS Coordinator on 05/23/19. 2) Measures for residents with potential to be affected: A 100% audit was completed by the MDS	

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F 636	Continued From page 29 was discharged on 3-6-19. During a review of Resident #1's MDS it was noted the resident had a quarterly assessment completed on 1-14-19 but the discharge assessment on 3-6-19 was still open and had not been completed. The MDS coordinator was interviewed on 5-23-19 at 1:15pm. The coordinator stated "I just missed it. I am used to a different electronic medical record system that gives you a list of tasks to be completed and this system does not do that, so I just missed it." During an interview with the Administrator on 5-23-19 at 4:10pm, the Administrator stated the MDS coordinator was new and was used to a different computer system but that she expected all comprehensive assessments to be completed per the RAI guidelines and timeframes. 2. Resident #2 was admitted to the facility on 10-11-18 with multiple diagnosis that included urinary tract infection, cerebrovascular accident, dementia and seizure disorder. Resident #2 was discharged on 2-11-19. Resident #2's MDS was reviewed for accuracy and the last assessment completed was a quarterly assessment on 1-15-19. During an interview with the regional MDS nurse and the facility MDS coordinator on 5-23-19 at 1:30pm, the MDS coordinator initially stated the discharge MDS should have been completed by the interim MDS coordinator because she was not hired at that time. The regional MDS nurse stated the facility had an as needed MDS	F 636	Coordinator as of 6/20/19 of all discharges from 02/01/19 thru 05/23/19 to ensure completion & timing of discharged assessment. Any resident assessment found to be missing a discharge MDS assessment was completed & transmitted. 3) Systemic Change: On 05/23/19, the MDS Regional Consultant in-serviced the facility MDS Coordinator on Comprehensive assessment & Timing of assessment per RAI guidelines. Newly hired MDS nurses will be in-serviced during the orientation period to accurately assess and coding of the MDS per the RAI guidelines. The Missing OBRA Assessment report will be requested weekly for 3 months and then monthly there after by the MDS Coordinator and a copy provided to Executive director. MDS Consultant will audit monthly for (3) months for completeness. 4) Monitoring: The results of the audits will be presented by the Executive Director in the QAPI committee for a minimum of three (3) months. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three (3) months.	

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F 636	Continued From page 30 coordinator from the end of January 2019 to February 5th, 2019 when the current MDS coordinator started her employment. The MDS coordinator denied she was in training when the discharge MDS for Resident #2 should have been completed "No I was here working, there was just a lot going on during that time." During an interview with the Administrator on 5-23-19 at 4:10pm, the Administrator stated the MDS coordinator was new and was used to a different computer system but that she expected all comprehensive assessments to be completed per the RAI guidelines and timeframes.	F 636	Effective 6/20/19, the facility Administrator and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction to ensure the facility attains and maintains substantial compliance.	
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a significant change in status assessment (SCSA) Minimum Data Set (MDS) following an evaluation and determination of a Level II PASARR (Pre - Admission Screening and Resident Review) for 1 of 1 resident	F 637	1)Measures for affected residents: Resident #53 had a significant change Minimum Data Set (MDS) completed by the facility MDS Coordinator on 06/17/19.	6/20/19

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F 637	Continued From page 31 reviewed for Level II PASARR (Resident # 53). Findings included: Resident # 53 was admitted to the facility on 01/29/2019 with diagnoses that included major depression, muscle weakness, edema and need for personal care assist. A review of a comprehensive admission MDS dated 02/05/2019 revealed that Resident # 53 was coded at A 1500 with no Level II PASARR. Resident # 53 was coded with moderate cognitive impairment, incontinent of bowel and bladder and had received 7 days of antianxiety medication. Resident # 53 had a care plan dated as initiated on 04/10/2019 that revealed in part that Resident # 53 had a Level II PASARR and that she would remain in the skilled nursing facility for as long as care was appropriate and needed. Interventions included in part that the Level II PASARR would be reviewed as needed, the physician (MD) would be notified if Resident # 53 had a significant change in status, a psychiatric referral would be obtained if indicated and the social worker (SW) would counsel Resident # 53 as needed for behavioral changes. A review of the medical record for Resident # 53 conducted on 05/21/2019 revealed that a quarterly MDS dated 04/11/2019 was completed. The record review also revealed that the face sheet of Resident # 53 listed a Level II PASARR status and there was no identified MDS for Resident # 53 coded with a Level II PASARR at A 1500 in the medical record for Resident # 53. On 05/21/2019 at 11:14 AM an interview	F 637	2)Measures for residents with potential to be affected: On 5/23/19, the corporate clinical reimbursement nurse completed an audit of current residents who have a Level II PASSR (Pre-Admission Resident Status Review) to ensure accuracy of MDS assessment and determine need for significant change MDS based on criteria from the RAI Manual. No other residents were identified as needing a significant change MDS. 3) Systemic Change: During daily clinical meeting (Monday-Friday), the IDT will discuss resident changes including PASSR level changes or any other major decline or improvement in the resident's status to determine if a significant change Minimum Data Set is needed. As of 6/20/19, The Corporate Clinical Reimbursement Nurse has re-educated the Interdisciplinary team (IDT) which includes MDS Coordinator, nursing management, dietary manager, social worker, activity director and therapy director on the criteria for significant change assessments based on the RAI Manual, and specifically related to PASRRs (Preadmission Screening and Resident Review) and the need to complete a significant change within 14 days should a resident's PASRR level change. Education also included other types of significant changes and the	

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F 637	Continued From page 32 conducted with the facility SW revealed that Resident # 53 was admitted to the facility from another state on 01/29/2019 without a PASARR status for North Carolina. The SW revealed that she had faxed the required documentation to North Carolina Department of Health and Human Services Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) on 01/29/2019. The SW revealed that the Level II PASARR status of Resident # 53 was not provided to the facility by DMH/DD/SAS until 02/12/2019 for major depression. The SW revealed that the MDS coordinator coded PASARR levels as recorded on the face sheet of each resident at the time of a comprehensive MDS. The SW also revealed that she provided the MDS coordinator with a list of Level II PASARR resident names monthly. On 05/23/2019 at 8:39 AM an interview with the MDS coordinator revealed that she did not code Resident # 53 with a Level II PASARR on the MDS dated 02/05/2019 because Resident # 53 did not have a PASARR Level II at that time per the medical record review of Resident # 53 or the PASARR Level II list that the SW provided to the MDS coordinator prior to 02/05/2019. The MDS coordinator revealed that she was aware that Resident # 53 received a Level II PASARR on 02/12/2019 but that she was not aware that she needed to complete a SCSA MDS within 14 days of receipt of the Level II PASARR status for Resident # 53. An interview conducted with the facility administrator on 05/23/2019 at 9:10 AM revealed that the expectation was that all residents were preferably admitted to the facility with an accurate and current PASARR Level status or if needed	F 637	definition of significant changes. Interdisciplinary Team Members not available for education will ot be allowed to work until education is completed. Newly hired MDS Coordinators and IDT members will be educated during their orientation period by the Director of Nursing regarding significant changes and the need for a significant change careplan within 14 days after the significant change is determined. 4)Monitoring: The Administrator will monitor daily clinical meeting weekly for (12) weeks to ensure IDT reviews any of resident changes for the need for significant change MDS based on PASSR level changes or other significant changes. This monitoring will continue monthly x 9 months. The results of the audits will be reported to the facility QA Committee by the Administrator monthly for a minimum of three 12 months for evaluation of compliance and ongoing monitoring for the continuous improvement. Effective 6/20/19, the facility Administrator and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction to ensure the facility attains and maintains substantial compliance.	

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F 637	Continued From page 33 the facility obtain a current PASARR Level within but no later than 30 days of admission to the facility. The administrator reveled that it was also expected that PASARR levels be coded correctly on an admission MDS or a SCSA MDS as required by the RAI (Resident Assessment Instruction) manual.	F 637		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews the facility failed to code the Minimum Data Set (MDS) assessment correctly for 3 of 37 Residents, Residents #28, Resident #30, and Resident #88, reviewed for MDS accuracy. The facility incorrectly coded Resident #28 as receiving anticoagulant therapy; Resident #30 as not having a pressure ulcer; and Resident #88 for smoking during the assessment period. Findings included: 1. Resident #30 was admitted to the facility on 1/19/18 and readmitted on 5/17/19. Her diagnoses were listed as dementia, hypertension, and need for assistance with personal care. A care plan dated 3/16/19 revealed Resident #30 had an unstageable pressure ulcer to the right buttock and a stage 3 pressure ulcer to the left heel. The most recent quarterly MDS assessment	F 641	1) Measures for affected residents: Resident # 28 - Minimum Data Set (MDS) assessments dated, 03/31/19 was modified on 5/23/19 by the facility MDS Coordinator to reflect no anticoagulant received during the lookback period for Section N □ Medication. Resident #30 □ Minimum Data Set (MDS) assessments dated 03/23/19 and 05/13/19 were amended on 06/17/19 by the facility MDS Coordinator to reflect accuracy of section M skin condition. Resident # 88 - Minimum Data Set (MDS) assessments dated, 12/14/18 was modified on 06/17/19 by the facility MDS Coordinator to reflect current Tobacco use during the lookback period for Section J □ Health Conditions. 2) Measures for residents who are	6/20/19

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F 641	Continued From page 34 dated 3/23/19 revealed Resident #30 was severely cognitively impaired; required extensive assistance with moving in bed, transfers, and toileting; and did not have a pressure ulcer. A review of a Wound Assessment dated 3/20/19 revealed Resident #30 had an unstageable pressure ulcer to the right buttock and a stage 3 pressure ulcer to her left heel. An interview with the Wound Nurse on 5/22/19 at 11:31 AM revealed Resident #30 had a stage 3 pressure ulcer to her right hip and a deep tissue injury to her sacrum, which would be unstageable. She stated Resident #3 had a wound on her heel that was unstageable to begin with but was later changed to by the wound physician to an arterial wound after results of an ultrasound. During an interview on 5/23/19 at 3:45 PM the Minimum Data Set (MDS) Nurse stated she would have coded the MDS by what was on the Wound Report that is given to her by the Wound Nurse. She stated if the report was not correct then she would have coded the MDS incorrectly. An interview with the Director of Nursing on 5/23/19 at 4:25 pm revealed the wound report is brought to the morning meeting each morning and discussed with the intradisciplinary team. She stated the MDS Nurse would be given a copy of the report by the Wound Nurse. She stated the Pressure Ulcers should have been recorded correctly on the MDS by the MDS Nurse. An interview with the Administrator on 5/23/19 at 5:15 pm revealed her expectation was the MDS should be coded correctly.	F 641	potential to be affected: Current residents most recent and completed MDS assessment will be audited by the MDS Coordinator to ensure all anticoagulant, smoking use and Skin condition are appropriately and accurately coded on the MDS. Any resident assessment found to have incorrect or omitted coding will be modified. 3) Systemic Change: On 06/14/19, MDS Regional Consultant in-serviced the MDS Coordinator on accurately assessing residents and coding of the MDS assessment per the RAI guidelines. MDS Consulatant will complete a 10% sample audit of the MDS assessments completed each month to ensure anticoagulant, Smoking use and Skin condition are being accurately assessed iand coded on the MDS per RAI Manual. Audits will be completed bi-monthly for three months. Newly hired MDS nurses will be in-serviced during the orientation period to accurately assess and coding of the MDS per the RAI guidelines. 4) Monitoring: The results of the audits will be presented by the Executive Director or designee in the QAPI committee for a minimum of	

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F 641	Continued From page 35 2. Resident #28 was admitted to the facility on 3/24/19 and diagnoses included atrial fibrillation and myocardial infarction. Review of the March 2019 medication administration record for Resident #28 revealed he received Brilinta (an antiplatelet medication) 90 milligrams (mg) every 12 hours for coronary artery disease. An admission minimum data set (MDS) dated 3/31/19 for Resident #28 revealed he had received an anticoagulant medication for 7 days of the look-back period. An interview on 5/23/19 at 11:14 am with the MDS nurse revealed she had completed the admission MDS assessment for Resident #28. She stated she wasn ' t familiar with the medication Brilinta and when she looked it up she thought it was an anticoagulant and coded it as this on the MDS. An interview on 5/23/19 at 2:52 pm with the MDS consultant revealed she had confirmed with their pharmacist that Brilinta was an antiplatelet medication and should not have been coded as an anticoagulant. She added the MDS nurse had completed a correction for the MDS. An interview on 5/23/19 at 3:07 pm with the Administrator revealed she expected the MDS to	F 641	three (3) months. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three (3) months. Effective 6/20/19, the facility Administrator and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction to ensure the facility attains and maintains substantial compliance.	

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F 641	Continued From page 36 be coded according to the guidelines. 3. Resident #88 was admitted to the facility 11/26/2018 and readmitted 12/7/2018 with diagnoses to include diabetes, depression and hypertension. The admission Minimum Data Set (MDS) assessment dated 12/14/2018 assessed Resident #88 to be cognitively intact. The MDS further assessed Resident #88 as not using tobacco. A safe smoking assessment dated 12/7/2018 assessed Resident #88 to be a safe smoker. A care plan dated 2/27/2019 was in place that addressed Resident #88 smoking cigarettes and included interventions to promote smoking safety. Resident #88 was observed smoking a cigarette in the facility designated smoking area on 5/19/2019 at 12:48 PM. Resident #88 was interviewed on 5/22/2019 at 5:57 PM and he reported he was using tobacco on his admission to the facility 12/7/2018. The MDS nurse was interviewed on 5/23/2019 at 11:23 AM and she reported she had not completed the MDS assessment dated 12/7/2018, but Resident #88 should have been coded as using tobacco. The Director of Nursing was interviewed on 5/23/2019 at 3:46 PM and she reported it was her expectation the MDS was coded accurately.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3)	F 655		6/20/19

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F 655	Continued From page 37 §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions.	F 655		

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F 655	Continued From page 38 (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and resident interviews, the facility failed to develop baseline care plans for 2 of 3 residents (Resident # 147 and Resident # 198) and failed to develop a discharge baseline care plan for 1 of 3 residents (Resident # 146) reviewed for baseline care plans. Findings included: 1. Resident # 147 was admitted to the facility on 05/10/2019 with diagnoses that included septic shock, alcohol cirrhosis, chronic viral hepatitis C, encephalopathy, major depression and lower extremity deep vein blood clot (DVT). An admission MDS (Minimum Data Set) dated 05/17/2019 was marked as in progress in the electronic medical record (EMR). There were no comprehensive care plans in progress at that time. On 05/21/2019 at 9:35 AM Resident # 147 was interviewed and she revealed that she had met with a group of facility staff about 2 days after her admission and that the group discussed her plan of care at the facility, but Resident # 147 did not recall signing any paperwork and had not received a copy of her plan of care from facility staff since she had been admitted. On 05/22/2019 at 8:30 AM a review of the	F 655	1) Measure for affected residents: Resident #147's Baseline Care Plan was located in the resident's chart, signed by the resident,this was in the residents chart along with the blank Baseline Care-plan. The Blank Baseline care-plan was removed. The Baseline careplan was reviewed by the Social Services Director as of 6/20/19. Areas still relevant were continued onto the care plan. A copy of the baseline care plan was provided to the resident as of 6/20/19. Resident # 146's baseline care plan was completed by the Social Services Director to include discharge plans as of 6/20/19. Areas still relevant were continued onto the care plan. A copy of the Baseline Care Plan was provided to the resident as of 6/20/19. Resident #146's next MDS will reflect his current and accurate discharge plans. Resident #198 is no longer at the facility, therefore, no changes or additions were made to the careplan. 2) Measure for residents with potential to be affected:	

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F 655	Continued From page 39 medical record of Resident # 147 revealed that there was a blank form titled Baseline Care Plans observed in the medical record of Resident # 147. The form was not dated and did not have Resident # 147's name on it and there were no documented notes or check marks on the form. The facility social worker (SW) was interviewed on 05/22/2019 at 9:02 AM. The SW confirmed that the baseline care plans were handwritten on paper and maintained in the hard chart of each resident. The SW revealed that she did not recall that she documented any information on the baseline care plan for Resident # 147 because she must have overlooked the care plan. The SW revealed that she believed that nurse staff initiated the baseline care plans. The SW revealed that baseline care plans were to be initiated and completed within 48 hours of resident admission and that resident was to sign the baseline care plan and given a copy of the signed care plan. On 05/22/2019 at 11:15 AM licensed nurse # 1 was interviewed and revealed that she had nothing to do with the baseline care plans and she did not know anything about them. On 05/23/2019 at 2:44 PM the Director of Nurses (DON) made no response when she was informed during an administrator interview that Resident # 147 had a blank baseline care plan form in her medical record. The facility administrator was interviewed on 05/23/2019 at 2:44 PM and revealed it was expected that baseline care plans be developed and reviewed with each resident and or resident responsible party (RP) within 48 hours of admission and that each resident was to receive	F 655	An audit of 100% of baseline careplans was completed as of 6/20/19 by the Medical Records Director. There were 39 residents without Baseline Care-plans, those were residents with admission dates past 90 days, of those 39, all had comprehensive assessments and careplans completed. Of those with Baseline Care-Plans those were compared to the most recently completed MDS to ensure that the stated goals for discharge were accurately reflected on the MDS. There were no identified discrepancies between the stated goals and the MDS. 3)Systemic Change: All Baseline Care-plans will remain in the chart for a minimum of 18 months. The admitting nurse will implement the Baseline Care-Plans on all admissions, including those there for short term Respite stays, to include the following: Initial goals based on admission orders. Physician orders. Dietary orders. Therapy services. Social services to include discharge plans. PASARR recommendation, if applicable. The assigned nurse will review the Care-Plan with the resident or the resident's representative within 48 hours of admission. This will be explained in manner in which the resident or	

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F 655	Continued From page 40 a copy of the signed baseline care plan. 2.Resident # 146 was admitted to the facility on 04/12/2019 with diagnoses that included cerebral infarct, muscle weakness, reduced mobility and hemiplegia. On 05/19/2019 at 3:56 PM Resident # 146 was interviewed and revealed that he wanted to receive rehabilitation from PT (physical therapy) and OT (occupational therapy) and then he wanted to discharge home with his friend. Resident # 146 revealed that he was not able to recall if he received a copy of his baseline care plan or if he had a meeting with the interdisciplinary team since he was admitted to the facility. A medical record review of Resident # 146 conducted on 05/22/2019 revealed that the paper chart contained a form titled Baseline Care Plan that was dated 04/12/2019 was signed by 4 staff members and Resident # 146. The section of the baseline care plan under the heading of Social Services did not include the discharge plans for Resident # 146. An admission MDS (Minimum Data Set) dated 04/19/2019 revealed that Resident # 146 was cognitively intact and experienced 1 to 3 days of verbal behaviors and other behaviors that interfered with care. Resident # 146 participated in the MDS and planned to remain in the facility for long term care. On 05/22/2019 at 9:02 AM the facility social worker (SW) was interviewed and revealed that Resident # 146 was planned to remain at the facility for long term care. The SW revealed that	F 655	responsible party is able to understand. The resident or responsible party will be provided a summary of the baseline careplan. As of 6/20/19 Residents will be interviewed pertaining to their goals and these will be accurately reflected on the Baseline Care-plan and the admission MDS. The Nurses and the Interdisciplinary Team (Includes: Social Services Director, Social Services Assistant, The Dietary Manager or Assistant Dietary Manager, The RN Assessment nurse and Unit Coordinator for A side and Unit Coordinator for B side and the Activity Director) were educated as of 6/20/19 regarding Baseline Care plans by the Director of Nursing, The Assistant Director of Nursing or the Administrator. The Social Services Director was educated on the need to interview residents regarding their discharge goals and to ensure that the MDS is accurately coded regarding this. 4) Monitoring: Effective 6/20/19 Baseline Care plans will be reviewed within 48 hours of admission by the Clinical Management team (includes Director of Nursing, Assistant Director of Nursing, Unit Coordinator	

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F 655	Continued From page 41 Resident # 146 reviewed his baseline care plan with the facility interdisciplinary team within 48 hours of admission and had been given a copy of the baseline care plan after he signed it. The SW revealed that she was not aware that Resident # 146's discharge plans should have been addressed on the baseline care plan and that she did not include discharge plans on the baseline care plans especially if the plan was to remain at the facility for long term care. On 05/23/2019 at 2:39 PM the facility administrator was interviewed and revealed that it was expected that baseline care plans be completed for each resident within 48 hours of facility admission and that resident discharge plans were to be included on the baseline care plans under the Social Service section. The administrator expected the baseline care plan be reviewed and signed by the resident or the responsible party (RP) and that a copy of the baseline care plan was to be provided to the resident. On 05/23/2019 at 2:44 PM the facility administrator revealed it was her expectation that discharge planning begin when a resident was admitted to the facility. 3. Resident #198 was admitted to the facility on 10/5/2018 and discharged on 10/16/2018 with diagnoses to include Alzheimer ' s disease. Resident #198 was admitted for respite care. The discharge Minimum Data Set dated 10/16/2018 assessed Resident #198 to be severely cognitively impaired with physical behaviors 1-3 days.	F 655	B-Side, Unit Coordinator A-Side, The Dietary Manager, The Social Services Director, The Activity Director) Monday through Friday to ensure the Baseline Careplan was completed within 48 hours of admission and a copy was provided to the Resident or Responsible Party Effective 6/20/19 Baseline Care plans will be audited within 48 hours of admission by the Weekend Supervisor to ensure the Baseline Care-Plan was completed within 48 hours of admission and copy provided to the Resident or Responsible Party. Baseline Careplans will be audited on Monday following a weekend admission and updated with any changes. The Social Services Director will interview the Resident or Responsible Party to ensure that the Baseline Care-Plan was provided and explained. The RN Assessment nurse will audit 5 MDS' a month x 12 months and compare to the Base Line Care-plan to ensure accurate coding of discharge plans. The Director of Nursing or the Assistant Director of Nursing will compile a report on the findings of these audits and report for the Quality Assessment and Performance Improvement (QAPI) committee monthly x one year. The Quality Assurance and Performance Improvement committee will make changes to the plan as necessary.	

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F 655	Continued From page 42 A review of the medical record for Resident #198 revealed no care plans were initiated or in place. Nurse #3 was interviewed on 5/21/2019 at 3:31 PM and she reported she had completed the admission assessment on Resident #198, but she was not certain why no baseline care plan was initiated. The facility social worker (SW) was interviewed on 05/22/2019 at 9:02 AM. The SW confirmed that the baseline care plans were handwritten on paper and maintained in the hard chart of each resident. The SW revealed that she did not recall that she documented any information on the baseline care plan for Resident #198 because she must have overlooked the care plan. The SW revealed that she believed that nurse staff initiated the baseline care plans. The SW revealed that baseline care plans were to be initiated and completed within 48 hours of resident admission and that resident was to sign the baseline care plan and given a copy of the signed care plan. The Director of Nursing (DON) was interviewed on 5/23/2019 at 3:46 PM and she reported that it was her expectation a baseline care plan was initiated for all residents on admission. The Administrator was interviewed on 5/23/2019 at 5:11 PM and she reported the staff had been instructed to initiate baseline care plans on all residents, including respite admissions. The Administrator reported nursing staff did not realize a respite admission required all admission forms to be completed.	F 655	Effective 6/20/19, the facility Administrator and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction to ensure the facility attains and maintains substantial compliance.	

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F 656	Continued From page 43	F 656		
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 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	F 656		6/20/19

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F 656	Continued From page 44 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 record review, observation and staff interviews, the facility failed to develop a comprehensive person-centered plan to address discharge plans for 1 of 1 residents reviewed (Resident # 146). Findings included: Resident # 146 was admitted to the facility on 04/12/2019 with diagnoses that included cerebral infarct, muscle weakness, reduced mobility and hemiplegia. On 05/19/2019 at 3:56 PM Resident # 146 was interviewed and revealed that he wanted to receive rehabilitation from PT (physical therapy) and OT (occupational therapy) and then he wanted to discharge home with his friend. An admission MDS (Minimum Data Set) dated 04/19/2019 revealed that Resident # 146 was cognitively intact and experienced 1 to 3 days of verbal behaviors and other behaviors that interfered with care. Resident # 146 participated in the MDS and planned to remain in the facility for long term care. A review of the comprehensive care plans for Resident # 146 revealed that the comprehensive care plans were developed on 04/12/2019 through 05/06/2019. There was no comprehensive care plan for Resident # 146 that	F 656	1) Measures for affected residents: Resident #146 care plan was updated on 05/23/19 to reflect discharge plans by the facility MDS (Minimum Data Set) Coordinator. 2) Measures for residents with potential to be affected: By 06/20/19, a comprehensive care plan audit will be conducted by the facility MDS Coordinator for current facility residents to ensure discharge plans are evident on the comprehensive care plan. 3) Systemic Change: By 06/20/19, the MDS Consultant will provide re-education to the IDT (Interdisciplinary Team) which includes the MDS Coordinator, Social Worker, Activities Director, Dietary, Therapy Director and Nursing Management of the development of comprehensive care plans which should include utilizing care areas identified on the care area summary (CAA) of the MDS. Ongoing, newly hired MDS and IDT staff will receive education during their orientation period by the MDS Consultant or MDS Consultant.	

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F 656	Continued From page 45 included his discharge plans. On 05/22/2019 at 9:02 AM the facility social worker (SW) was interviewed and revealed that Resident # 146 planned to remain at the facility for long term care. The SW revealed that she did not write a comprehensive care plan for Resident # 146 because he planned to remain at the facility for long term care. The SW revealed that she had not been made aware that she needed to write a comprehensive discharge care plan for residents especially if the plan was to remain in the facility for long term care as were the plans of Resident # 146. The SW stated that she would write a progress note if a resident changed plans for discharge. On 05/23/2019 at 2:39 PM the facility administrator was interviewed and revealed that it was expected that each resident have a comprehensive discharge care plan that was reviewed at least quarterly and as needed. On 05/23/2019 at 2:44 PM the facility administrator added that she expected discharge plans to begin on admission and continue to be reviewed and revised with all comprehensive care plans on an ongoing basis.	F 656	Monthly for (3) months, the MDS Consultant will audit completed comprehensive care plans to ensure all triggered care areas have been addressed including ensuring discharge plans are outlined. 4) Monitoring: Monthly for a minimum of three (3) months, the Administrator will report the results of the audits to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three (3) months. Effective 6/20/19, the facility Administrator and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction to ensure the facility attains and maintains substantial compliance.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to--	F 657		6/20/19

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F 657	Continued From page 46 (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 record review, resident and staff interviews the facility failed to conduct a care plan review plan within seven days of a comprehensive assessment for 1 of 3 residents reviewed for care plans (Resident #85) and failed to revise and update a care plan regarding a resident's wounds for 1 of 3 residents reviewed for care plans (Resident #12). The findings included: 1. Resident #85 was admitted on 5/24/18 and the resident's cumulative diagnoses included: Multiple Sclerosis (MS), sickle cell disease, chronic pain, diabetes, depression, bipolar disorder, schizophrenia, and generalized weakness.	F 657	1)Measures for affected residents: Resident #85 care plan was reviewed and revised by the facility Interdisciplinary Team (IDT) which includes nursing management, social worker, activities director, dietary manager on 5/29/19. Resident #12 care plan was updated by the facility Minimum Data Set Coordinator on 06/17/19 to reflect presence of wound(s) and interventions to address wound(s). 2)Measures for residents who have potential to be affected:	

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F 657	Continued From page 47 Review of Resident #85's most recent Minimum Data Set (MDS) revealed an annual comprehensive assessment with an Assessment Reference Date (ARD) of 4/25/19. The resident was coded as having been cognitively intact. The resident was coded as having had no hallucinations or delusions and the resident was coded as having had 1-2 occurrences through the assessment period of verbal behavioral symptoms directed toward others (examples, threatening others, screaming at others, cursing at others) which did not significantly impact the resident's health, significantly interfere with other residents, nor significantly interfere with the resident's participation in activities. Review Resident #85's care plan revealed the most recent revision was entered on 3/21/19 and was regarding a wound the resident had. Review of the Care Plan Meetings sheet revealed the last care plan meeting was for a quarterly review and it was on 12/5/19 and the participants were a representative from dietary, nursing, and social work. Review of the Resident Care Planning Conference sheet revealed participants from nursing, dietary, social work, and a resident family member met on 12/5/19. Further review revealed a care plan review had been completed for a quarterly review on 12/24/18. During an interview conducted with Resident #85 on 5/19/19 she stated she had not attended a care plan meeting. An interview was conducted with the Social Worker (SW) was conducted in conjunction with a record review on 5/21/19 at 10:31 AM. The SW stated she had invited Resident #85 via a written	F 657	As of 6/20/19, an audit was conducted of current facility residents by the MDS Coordinator to ensure care plan reviews are current. Additionally, an audit was conducted as of 06/20/19 by the MDS Coordinator to ensure current residents with wounds have care plans with interventions to address wounds. 3)Systemic Change: Effective 6/20/19 an Interdisciplinary meeting will be held weekly to review the MDS schedule and review careplan schedules to ensure that careplans are completed timely following an assessment. As of 6/20/19, the facility IDT will be re-educated by the Director of Nursing on ensuring timely updates of resident care plan when plan of care changes and completion of timely care plan reviews by the IDT. Newly hired IDT members will be educated during their orientation period. Physician Orders and Nursing Notes will be reviewed by Nursing Management during the facility daily clinical meeting (Mon-Fri) for changes in orders to ensure care plan has been updated as applicable. Additionally, Director of Nursing will review physician orders and nursing notes weekly for 3 months for changes in orders to ensure care plan has been updated as applicable. 4) Monitoring:	

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F 657	Continued From page 48 invitation distributed in the facility and had invited a family member of the resident for the last care plan meeting which took place on 1/9/19. The SW stated she had sent the invitation to resident's family member on 12/31/19 and the resident's family did attend, but the resident chose not to attend. The SW stated the resident should have been coming up for another care plan meeting. The SW stated she followed the MDS schedule which she received from the MDS nurse. The SW stated the care planning conference sheet was in the resident's medical record. Upon reviewing the care planning conference sheet, she stated the last care plan meeting held for the resident was on 12/5/18 and the resident's family member had attended. The SW stated the copy of the care plan in the resident's chart was the current and active care plan and any updates to it were handwritten. A second interview was conducted with the SW on 5/23/19 at 11:48 AM. The SW stated she coordinated the care plan reviews. She stated Resident #85 had her last care plan review on 1/9/19 and she had not had a care plan review since nor did she have a care plan review scheduled for the residents. The SW stated the care plan review for Resident #85 should have been coming up on the schedule for next week. She stated she received a schedule from the MDS nurse but that was not the only calendar she used to coordinate care plan reviews. She stated she also would go back through her notes and look for a resident's last care plan. The SW stated Resident #85 was not on the schedule, but she would be added based on her last assessment, which was an annual comprehensive assessment with an ARD of 4/25/19. The SW stated each resident's care	F 657	Weekly for (12) weeks, then quarterly x 9 months the Director of Nursing will review documentation from the morning clinical rounds to ensure that the careplans have been updated to reflect any changes,these audits will include careplans for wounds. The DON will report the results of the audits to the Quality Assurance and Performance Improvement Committee monthly x 3 months, then quarterly x 9 months. The Quality Assurance and Performance Improvement (QAPI) committee will make changes to the plan as necessary. Effective 06/20/19, the facility Administrator and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction to ensure the facility attains and maintains substantial compliance.	

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F 657	Continued From page 49	F 657		

plan needed to be reviewed quarterly, or every three months, or after an assessment. The SW stated she was behind on scheduling the care plan reviews, including for Resident #85, because Resident #85's last care plan review was on 1/9/19 and they are catching up on care plans.

During an interview with the Director of Nursing on 5/23/19 at 12:05 PM she stated it was her expectation for each resident's care plan to be reviewed quarterly, on a regular basis, and as per the regulations.

During an interview conducted with the Administrator on 5/23/19 at 1:24 PM she stated it was her expectation for care plans to be updated, changes made to the care plan as needed, and for care plan reviews to be conducted quarterly, significant change, and annual assessments.

2. Resident #12 was admitted to the facility on 11/14/18 with diagnoses of hemiplegia, stroke, diabetes, heart disease, alcohol dependence, and difficulty swallowing.

A quarterly Minimum Data Set (MDS) assessment dated 2/2/19 revealed Resident #12 was cognitively intact and required extensive assistance with activities of daily living. The assessment also revealed Resident #12 had three pressure ulcers.

Resident #12's Care Plan dated 12/16/18 revealed he had an unstageable pressure ulcer to his left heel. The Care Plan had not been updated with the information on the quarterly MDS assessment dated 2/2/19.

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F 657	Continued From page 50 During an interview with the MDS Nurse on 5/23/19 at 3:05 PM she stated Resident #12's Care Plan had not been updated since 12/16/18 and the arterial ulcers were not included in the Care Plan. The MDS Nurse stated the care plan should have been updated when the arterial ulcers were identified and at least quarterly. An interview with the Director of Nursing on 5/23/19 at 4:25 pm revealed her expectation was Resident #12's Care Plan should be updated every quarter and with any change in the resident's wounds. During an interview with the Administrator on 5/23/19 at 5:14 pm she revealed her expectation was the Care Plans should be updated at least quarterly and as needed.	F 657		
F 680 SS=C	Qualifications of Activity Professional CFR(s): 483.24(c)(2)(i)(ii)(A)-(D) §483.24(c)(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who- (i) Is licensed or registered, if applicable, by the State in which practicing; and (ii) Is: (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or (B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or (C) Is a qualified occupational therapist or occupational therapy assistant; or	F 680		6/20/19

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F 680	Continued From page 51 (D) Has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure the Activity Director was certified by an approved accrediting body. Findings included: The Activity Director job description (no date) was reviewed, and it read, in part: education/experience "has completed a training program approved by the state" and "certification as a Therapeutic Recreation Specialist (TRS) desirable." An interview was conducted with the Assistant Activity Director (AAD) on 5/23/2019 at 9:17 AM and she reported she had stepped down from the Activity Director position about 4 weeks prior. The AAD reported she was not certified as a TRS. . An additional interview was conducted with the AAD on 5/23/2019 at 2:27 PM and she reported she had been the Activity Director from late 2017 until June of 2018, and from September 2018 until April of 2019. The AAD reported she had signed up for certification classes but had not taken the class. The Administrator was interviewed on 5/23/2019 at 5:09 PM and she reported she was aware the AAD was not certified and the current Activity Director, (who was certified as a TRS) was hired in February 2019 and started her position in April 2019. The Administrator reported it was her expectation the Activity Director was certified as a TRS.	F 680	1) Measures for affected resident: A qualified Activity Director was hired effective 4/22/19 2) Measures for resident with potential to be affected: All residents have the potential to be affected by this same deficient practice. 3) Systemic Change: Effective 6/20/19 there will be no unqualified Activity Directors employed. The Administrator was educated as of 6/20/19 by the Regional Nurse Consultant on the requirement to have a qualified Activity Professional employed fulltime. 4)Monitoring: The Administrator will audit the qualifications monthly and report to the Quality Assurance and Process Improvement committee annually. The Quality Assurance and Process Improvement committee will make changes to the plan as necessary. Effective 6/20/19, the facility Administrator and the Director of Nursing will be	

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F 680	Continued From page 52	F 680	ultimately responsible for the implementation of this plan of correction to ensure the facility attains and maintains substantial compliance.	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 732		6/20/19

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F 732	Continued From page 53 §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on review of the daily nurse staffing forms, nursing schedules and staff interviews, the facility failed to accurately report care hours provided by licensed and unlicensed personnel for 9 out of 9 daily posted nurse staffing forms reviewed. Findings included: 1. Review of the facility's daily nursing staffing forms and daily nursing schedules for 3/29/2019, 3/30/2019. 3/31/2019, 4/20/2019, 4/21/2019, 4/22/2019, 5/7/2019, 5/8/2019, and 5/9/2019 revealed the daily nursing staffing forms were not accurate on the following 9 of 9 days: a. The nursing schedule for 1st shift (7:00 AM to 3:00 PM) for 3/29/2019 was reviewed and 1 Registered Nurse (RN), 3 Licensed Practical Nurses (LPN) and one Medication Technician (MT) were scheduled to work 1st shift. The daily posted nurse staffing sheet for 3/29/2019 indicated 2 RNs had provided 16 hours of care, 2 LPN had provided 16 hours of care and no MT was noted on the daily posted nurse staffing sheet. b. The nursing schedule for 1st shift for 3/30/2019 was reviewed and 1 MT and 8 nursing assistants (NA) were scheduled to work. The daily posted staffing sheet indicated no MT provided care and 9 NAs provided 67.5 hours of	F 732	1) Measures for affected residents: The Posted Nursing Staffing Information were corrected for the following dates: 3/29/19, 3/30/19,3/31/19, 4/20/19, 4/21/19, 4/22/19, 5/7/19, 5/8/19 and 5/9/19 to reflect accurate data. 2)Measures for residents with potential to be affected: The Posted Nursing Staffing Information forms were audited by the Administrator as of 6/20/19 for one month to determine if nursing staffing hours and census information was reported accurately. 3) Systemic Change: The Director of Nursing, The Assistant Director of Nursing and the Staffing Coordinator were educated regarding the completion of the Posted Nursing Staffing Information forms and the correct process for completion. The Director of Nursing or the Assistant Director of Nursing will assist in the completion of these form going effective 6/20/19 to ensure accuracy. 4)Monitoring:	

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F 732	Continued From page 54 care. The nursing schedule for 2nd shift (3:00 PM to 11:00 PM) was reviewed and 4 LPNs were scheduled to work. The daily posted nurse staffing sheet indicated 3 LPN had provided 24 hours of care. The nursing schedule for 3rd shift (11:00 PM to 7:00 AM) was reviewed and 3 LPNs were scheduled to work 3/30/2019 and the daily posted nurse staffing sheet indicated 2 LPNs had provided 16 hours of care. c. The nursing schedule for 1st shift on 3/31/2019 was reviewed and 4 LPNs were scheduled to work. The daily posted nurse staffing sheet indicated 3 LPNs had provided 24 hours of care. The nursing schedule for 3/31/2019 2nd shift revealed 4 LPNs and 5.5 NA were scheduled to work, and 1 NA had left early (no time documented). The daily posted nurse staffing sheet indicated 3 LPN had provided 24 hours of care and 6 NA had provided 45 hours of care. The nursing schedule for 3rd shift on 3/31/2019 revealed 3 LPNs and 6 NA were scheduled to work, and the daily posted nurse staffing sheet indicated 2 LPNs had provided 16 hours of care and 4 NAs had provided 30 hours of care. d. The nursing schedule for 4/20/2019 was reviewed and it revealed 1 MT was scheduled to work 1st shift on that date. The daily posted nurse staffing sheet indicated no MT had provided care. The nursing schedule for 4/20/2019 on 2nd shift revealed 3.5 LPNs, 5.5 NA and 0.5 MT were scheduled to work. The daily posted nurse staffing sheet indicated 4 LPNs had provided 32 hours of care, 7 NA had provided 52.5 hours of care and no MT provided care. The nursing schedule for 4/20/2019 3rd shift was reviewed,	F 732	The Director of Nursing or the Assistant Director of Nursing will audit the Posted Nursing Staffing Information forms daily, Monday through Friday for accuracy x one week. These forms will then be audited weekly x 3 weeks and then Monthly x 11 months. The Director of Nursing or the Assistant Director of Nursing will compile a report on the findings of those audits and present to the Quality Assurance and Process Improvement committee monthly x one year. The Quality Assurance and Process Improvement committee will make changes to the plan as necessary. Effective 6/20/19, the facility Administrator and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction to ensure the facility attains and maintains substantial compliance.	

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and 4 NAs were scheduled to work, and one NA arrived 1 hour after the shift started. The daily posted nurse staffing sheet indicated 5 NAs had provided 37.5 hours of care.

e. The nursing schedule for 4/21/2019 was reviewed and 6 NAs were scheduled to work 1st shift. The daily posted nurse staffing sheet indicated 8 NAs had provided 60 hours of care. The nursing schedule for 4/21/2019 for 2nd shift was reviewed, and 5.5 NAs were scheduled to work. The daily posted nurse staffing sheet indicated 7 NAs had provided 52.5 hours of care. The nursing schedule for 3rd shift on 4/21/2019 was reviewed, and 5 NAs were scheduled to work. The daily posted nurse staffing sheet indicated 4 NAs had provided 30 hours of care.

f. The nursing schedule for 4/22/2019 1st shift was reviewed, and 13 NAs were scheduled to work. The daily posted nurse staffing sheet indicated 12 NAs had provided 90 hours of care. The nursing schedule for 2nd shift on 4/22/2019 was reviewed and 6.5 NAs were scheduled to work. The daily posted nurse staffing sheet indicated 7 NAs had provided 52.5 hours of care.

g. The nursing schedule for 5/7/2019 was reviewed for 1st shift and 5 LPNs were scheduled to work. The daily posted nurse staffing sheet indicated 2 LPNs had provided 16 hours of care. The nursing schedule for 2nd shift on 5/7/2019 was reviewed, and 6 LPNs and 7 NAs were scheduled to work, with 1 NA scheduled to leave 30 minutes early. The daily posted nurse staffing sheet indicated 4 LPNs had provided 32 hours of care and 6 NAs provided 45 hours of care. The nursing schedule for 3rd shift on 5/7/2019 was

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reviewed, and 6 NAs were scheduled to work. The daily nurse staffing sheet indicated 5 NAs had provided 37.5 hours of care.

h. The nursing schedule for 5/8/219 1st shift was reviewed, 4 LPNs and 12.5 NAs were scheduled to work. The daily posted nurse staffing sheet indicated 3 LPNs had provided 24 hours of care and 12 NAs had provided 90 hours of care. The nursing schedule for 2nd shift on 5/8/2019 revealed 6.5 NAs and 1 MT were scheduled to work. The daily posted nurse staffing sheet indicated 6 NAs had provided 45 hours of care and no MT hours of care were documented. The nursing schedule for 3rd shift on revealed no RN was scheduled to work, 4 LPNs and 6 NAs were scheduled to work on 5/8/2019. The daily posted nurse staffing sheet indicated 1 RN had provided 8 hours of care, 3 LPNs had provided 24 hours of care and 5 NAs had provided 37.5 hours of care.

i. The nursing schedule for 5/9/2019 1st shift was reviewed, and 1 MT was scheduled to work. The daily posted nurse staffing sheet indicated no MT had provided care during that shift. The nursing schedule for 2nd shift on 5/9/2019 revealed 1 RN and 7 NAs were scheduled to work. The daily posted nurse staffing sheet indicated no RN had provided care for 2nd shift on 5/9/2019 and 6 NAs had provided 45 hours of care. The nursing schedule for 3rd shift on 5/9/2019 documented a 30-minute late arrival of on NA. the daily posted nurse staffing sheet did not adjust the total hours provided by the NAs to reflect the late arrival of the NA for that date.

The Director of Nursing (DON) was interviewed on 5/23/2019 at 3:31 PM and she reported the

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F 732	Continued From page 57 scheduler had been completing the daily posted nurse staffing sheets and correcting them during the day for staffing changes. The DON went on to explain she did not realize the daily posted nurse staffing sheets should be updated each shift to reflect the current staffing. The Administrator was interviewed on 5/23/2019 at 5:13 PM and she reported it was her expectation the daily posted nurse staffing sheets were updated in a timely manner to accurately reflect the current staffing of the facility.	F 732		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 761		6/20/19

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F 761	Continued From page 58 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to remove expired medications from one of one automated medication dispensing system and two of four medication carts inspected for medication storage (Cart 2 A-side and Cart 4 B-side). Findings included: 1. An observation of the automated medication dispensing system located in the A side medication room was conducted on 5/23/19 at 12:00 PM (noon). The observation revealed 4 Vitamin B 12 500 mg pills in 4 individual bubble packs with an expiration date of 5/14/19. Further observation revealed 5 Cefuroxeme Axetil 250 mg pills in 5 individual bubble packs with an expiration date of 5/14/19 and 10 Amoxicillin 250 mg pills in 10 individual bubble packs with an expiration date of 5/1/19. An interview was conducted on 5/20/19 at 12:28 PM with Unit Manager (UM1). UM1 stated the expectation was for medications in the automated medication dispensing system not to be expired so that they may be given to the resident when needed. The UM1 stated a representative from the pharmacy had been to the facility and conducted an audit on the medication in the dispensing system and she had restocked the dispensing system herself and was not aware there were expired medications in the dispensing system. The UM1 stated the pharmacist representative had been to the facility and audited the system once in the past 6 months.	F 761	1)Interventions for affected resident: Expired medications found in the Automated medication unit were discarded by the pharmacy consultant on 5/23/19. Expired medications found on the medication cart were discarded by the Unit Manager on 5/23/19. 2)Interventions for residents identified as having the potential to be affected: Pharmacy representative audited all med carts and the Automated medication unit on 5/23/19 to ensure no other medications were expired. No additional expired medications were identified in the Automated medication unit or on any medication cart. 3)Systematic Change: By 6/20/19, the Director of Nursing, Unit Manager or Staff development Coordinator will perform re-education with all Licensed Nurses regarding medication expiration dates and ensuring no medications are expired on the medication cart or in the Automated medication unit. Licensed Nurses who are unavailable for education will not be allowed to work until education is completed.	

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F 761	Continued From page 59 During an interview conducted with the Director of Nursing (DON) on 5/23/19 at 12:00 PM she stated it was her expectation to dispose of expired medications and restock with unexpired medications. An interview was conducted with the Administrator on 5/23/19 at 1:24 PM. The Administrator stated her expectation was through monitoring with the involvement of both pharmacy and nursing that expired medications be removed and discarded. 2. Per the manufacturer's guidelines for the mealtime insulin injectable pen; the insulin pen expires 28 days after first use and should be thrown away even if there is insulin left inside the pen. An observation was conducted of Cart 2 for the A side on 5/20/19 at 12:32 PM. The observation revealed 2 multi-dose insulin aspart injection pens. One was dated with an open date of 4/11/19 and the other was dated with an open date of 4/16/19. There were no expiration dates observed on either injection pen. Unit Manager #1, who was present during the observation, stated the multi-dose insulin aspart injection pens expire 28 days after opening and the two injection pens needed to be discarded. During an interview conducted with the Director of Nursing (DON) on 5/23/19 at 12:00 PM she stated it was her expectation to dispose of expired medications and restock with unexpired medications. An interview was conducted with the	F 761	Newly hired Licensed Nurses will be educated by the Staff Development Coordinator during their orientation period regarding medication expiration dates and ensuring no medications are expired on the medication cart and in the Automated medication unit. Director of Nursing, Unit Manager or Staff Development Coordinator will perform medication cart audits weekly for 12 weeks to ensure no medications are expired and all have an open date indicated on the original label or container. Director of Nursing, Unit Manager or Staff Development Coordinator will perform audit of the Automated medication unit monthly for 3 months to ensure no medications are expired. Pharmacy Consultant (Quality Assurance Monitor) will perform medication cart and Automated medication unit audits quarterly for a minimum of 2 quarters (6 months) to ensure there are no expired medications in the Automated medication unit or medication carts. 4)Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three (3) months, the Director of Nursing will report the results of the audits for expired medication to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance	

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F 761	Continued From page 60 Administrator on 5/23/19 at 1:24 PM. The Administrator stated her expectation was through monitoring with the involvement of both pharmacy and nursing that expired medications be removed and discarded. 3. An observation was conducted of Cart 4 for the B side on 5/20/19 at 12:55 PM. The observation revealed a 100-tablet bottle of a daily multivitamin with an expiration date of 2/2019 and there were some tablets remaining in the bottle. An interview was conducted on 5/20/19 at approximately 12:55 PM with Nurse #7. The nurse stated she read the expiration date as February 2019 and the medication was expired. The nurse stated she usually did check the expiration dates on the medications she was administering. The nurse stated she was unaware the medication was expired and would dispose of the expired medication. During an interview conducted with the Director of Nursing (DON) on 5/23/19 at 12:00 PM she stated it was her expectation to dispose of expired medications and restock with unexpired medications. An interview was conducted with the Administrator on 5/23/19 at 1:24 PM. The Administrator stated her expectation was through monitoring with the involvement of both pharmacy and nursing that expired medications be removed and discarded.	F 761	Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three (3) months. Effective 6/20/19, the facility Administrator and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction to ensure the facility attains and maintains substantial compliance.	
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must-	F 773		6/20/19

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F 773	Continued From page 61 (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on record review and staff and Nurse Practitioner interviews the facility failed to notify the Nurse Practitioner that they did not obtain ordered bloodwork or results of a chest x-ray that revealed pneumonia in 1 or 1 residents, Resident #10, investigated for prompt notification of laboratory and radiological results. Findings included: Resident #10 was admitted to the facility on 12/3/15 with diagnoses of heart failure, atrial fibrillation, hypertension, and dementia. The most recent Minimum Data Set (MDS) assessment, a quarterly assessment, dated 2/14/19 revealed Resident #10 was severely cognitively impaired and required limited to extensive assistance with all activities of daily living. A physician's order written 2/1/19 by the Nurse Practitioner requested a Basic Metabolic Panel, Complete Blood Count and Chest X-ray be completed stat. A stat order is an order to be completed immediately.	F 773	1) Measures for affected residents: Resident #10 no longer resides in the facility. 2) Measures for residents with potential to be affected: An audit utilizing new physician orders for the past 30 days was conducted on 6/14/19 by the Director of Nursing to ensure any new orders for lab or diagnostic testing was completed as ordered and results communicated timely to the Nurse Practitioner or Physician. Based on audit results, all ordered labs or diagnostics testing within the past 30 days have been completed and results communicated timely with the Nurse Practitioner or Physician. 3) Systemic Change: Effective 6/20/19 Licensed Nurses will report to the Physician if any labs or	

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F 773	Continued From page 62 A Nurse's Note dated 2/2/19 at 3:49 AM by Nurse #5 revealed she had attempted to obtain bloodwork for a Basic Metabolic Panel and Complete Blood Count but was unsuccessful and would notify the next shift. On 2/4/19 at 11:13 AM Nurse #3 entered a late entry note for 2/1/19 stating she had attempted to obtain the bloodwork for Resident #10 but was unsuccessful. A Nurse's Note dated 2/4/19 at 12:22 PM by Unit Manager #1 stated the Nurse Practitioner was notified of Chest X-ray results of patchy infiltrate medial right lower lung consistent with pneumonia. The note further revealed the Nurse Practitioner ordered antibiotics, Levaquin 750 milligrams every 48 hours for 6 doses and Augmentin 500 milligrams -125 milligrams every 12 hours for 7 days; Speech Therapy evaluation for aspiration pneumonia; vital signs every shift for 3 days; and notify Nurse Practitioner of changes in condition. The note also stated the Nurse Practitioner would notify the Family Member of the new orders. On 2/4/19 at 5:50 pm a Nurse's Note by Nurse #6 revealed the bloodwork was obtained for the Basic Metabolic Panel and Complete Blood Count ordered on 2/1/19. An interview on 5/20/19 at 4:11 pm with the Family Member revealed she had requested Resident #10 be seen by the Nurse Practitioner on 1/31/19 because her pulse was weak, and she was having difficulty breathing. The Family Member stated the Nurse Practitioner saw Resident #10 on 2/1/19 and ordered blood work	F 773	diagnostic tests are not able to be obtained as ordered. Effective 6/20/19 Licensed Nurses will communicate timely to the Physician the results of lab and diagnostic test results. Additionally, Licensed nurses will document on the 24-hour report is updated including outstanding lab and/or diagnostic tests. Each afternoon, Monday-Friday the Unit Coordinator-Side B and the Unit Coordinator for Side-A will review the ordered labs and the pending results for that day to ensure that labs were obtained, the results have been received and the Physician is notified. Each afternoon on weekends (Saturday and Sunday), the Weekend Supervisor or the Charge Nurse will review the ordered labs and the pending results for that day to ensure that labs were obtained, the results have been received and the Physician is notified. During clinical meeting (Monday - Friday), the 24- hour report, nurses notes and new physician orders will be reviewed by the Unit Managers to ensure timely completion and communication of results to Physician for labs and/or diagnostic test. On weekends (Saturday and Sunday), the Nursing Supervisor or Charge Nurse will review the 24-hour report, nurses note and new physician orders to ensure timely completion and communication of results to Physician for	

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F 773	Continued From page 63 and a chest x-ray. She stated the Nurse Practitioner did not get the results of the tests until the following Monday, 2/4/19, and Resident #10 was diagnosed with pneumonia. The Family Member stated she felt treatment was delayed because the facility did not obtain the blood work timely and did not report the results of the chest x-ray and blood work to the Nurse Practitioner timely. An interview with the Nurse Practitioner on 5/23/19 at 1:04 PM revealed she had ordered a chest x-ray, complete blood count, and complete metabolic panel to be done stat on 2/1/19 because Resident #10 was lethargic, and the Family Member was concerned because she was wheezing. She stated the chest x-ray was completed on 2/1/19 and showed pneumonia but she did not receive the results of the x-ray until 2/4/19 when she called to inquire about the results. The Nurse Practitioner stated the facility had failed to obtain the stat blood work on 2/1/19 and had not called to notify her it was not completed. The Nurse Practitioner further stated there was a delay in treatment of Resident #10 but thankfully the delay did not cause any harm to the resident. During and interview on 5/23/19 at 2:09 PM with Unit Manager #1 she stated she checked orders for the weekend on Monday, 2/4/19, and saw the results of the chest x-ray for Resident #10 and immediately called the Nurse Practitioner to report the abnormal results. She stated the blood work that was ordered stat on Friday, 2/1/19, should have been draw immediately and sent by courier to the laboratory and the results of both the abnormal chest x-ray and blood work reported to the Nurse Practitioner immediately.	F 773	labs and/or diagnostic test. By 6/20/19, The facility Director of Nursing or Staff development Coordinator will conduct an in-service with all Licensed Nurses on ensuring communication with the Physician if any labs or diagnostic tests are not able to be obtained as ordered, timely communication of lab and diagnostic test results to the Physician. Additionally, Licensed nurses will be educated on assuring the 24-hour report is updated to reflect outstanding lab and/or diagnostic test to ensure follow-up of completion and timely communication of results to the Physician. This includes education for the Unit Coordinators and Weekend Supervisor on audits to be performed daily. Newly hired Licensed Nurses will be educated during their orientation period on ensuring communication with the Physician if any labs or diagnostic tests are not able to be obtained as ordered, timely communication of lab and diagnostic test results to the Physician and the 24-hour report for effective communication between shifts. Newly hired Unit Coordinators or Weekend Supervisors will be educated at the time of hire on the audits to be performed each afternoon. Weekly for (12) weeks, the Director of Nursing will audit new physician orders to ensure timely completion and communication of results to Physician for	

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F 773	Continued From page 64 An interview with Nurse #6 on 5/23/19 at 2:14 PM revealed the blood work that was ordered stat on 2/1/19 was not drawn until 2/4/19. She stated she drew the blood work when she was told it had not been done and did not have any issues with the blood draw on 2/4/19. She stated the blood work should have been drawn on 2/1/19 since it was ordered stat and the Nurse Practitioner should have been notified the blood work was not obtained. On 5/23/19 at 2:18 PM an interview with Nurse #3 revealed she was not able to draw Resident #10's blood work on 2/1/19 and she did not remember if she notified the Nurse Practitioner or Physician. She stated she should have called the physician on call or the Nurse Practitioner when she was not able to obtain the blood work since it was ordered stat. During an interview with the Director of Nursing on 5/23/19 at 2:25 PM she stated the nurses should have attempted more than one time to obtain the blood work for Resident #10 on 2/1/19 since it was ordered stat and the abnormal chest x-ray should have been reported immediately to the Nurse Practitioner. She stated she expected the nurses to attempt at least twice to obtain blood work that is ordered stat and to notify the ordering physician or nurse practitioner immediately if they are not able to obtain it. She stated she also expected the nurses to notify the physician or nurse practitioner immediately of any abnormal x-rays. The Director of Nursing stated the nurse should have notified the responsible party they were not able to get the blood work and the results of the abnormal chest x-ray on 2/1/19.	F 773	labs and/or diagnostic tests. 4) Ongoing Monitoring: Monthly for a minimum of three (3) months, the DON will report the results of the audits to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three (3) months. Effective 6/20/19, the facility Administrator and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction to ensure the facility attains and maintains substantial compliance.	

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UNIVERSAL HEALTH CARE & REHAB	430 BROOKWOOD AVENUE NE CONCORD, NC 28025

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F 773	Continued From page 65 An interview with the Administrator on 5/23/19 at 5:14 pm revealed she expected the nursing staff to draw and report blood work and x-rays as ordered by the physician and nurse practitioner.	F 773		
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews the facility failed to follow the physicians order to avoid caffeine and artificial sweeteners. This was evident for 1 of 4 residents reviewed for food choices (Resident #78). Findings Included: Resident #78 was admitted to the facility on 2/13/18 and her diagnoses included diabetes, atherosclerotic heart disease, congestive heart failure, myocardial infarction and chronic obstructive pulmonary disease. A physician ' s order dated 12/3/18 for Resident #78 stated to avoid caffeine and artificial sweeteners. The diet order was Regular with no added salt (NAS) and no concentrated sweets (NCS).	F 808	1) Measures for residents affected: Resident # 78□s traycard has been updated to reflect □No caffeine and no artificial sweetners as of 6/20/19. 2) Measures for resident with the potential to be affected: An Audit of 100% of therapeutic diets was completed as of 6/20/19 by the Dietary Manager. Any traycards found without restrictions reflected were updated at the time of the audit. 3) Systemic Changes: Effective 6/20/19 The Dietary Manager or Assistant Dietary Manager will review new physicians orders for Therapeutic diets	6/20/19

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F 808	Continued From page 66 Review of the meal tray card for Resident #78, provided by the Dietary Manager (DM) revealed she was on a NAS, NCS diet. The tray card did not include to not serve caffeine or artificial sweetener. A quarterly minimum data set (MDS) dated 4/23/19 for Resident #78 identified she received a therapeutic diet and her cognition was intact. An observation and interview on 5/23/19 at 1:05 pm with Resident #78 revealed she was in her room eating lunch. A packet of artificial sweetener and 2 cups of coffee were served with her lunch meal. The resident stated she believed her heart doctor had told her not to use artificial sweeteners and she usually didn ' t use what was served because she drank her coffee black. The resident added she liked coffee and drank several cups with each meal. She stated she wasn ' t sure if the coffee she received was regular or decaffeinated, but she believed it was decaffeinated because her heart doctor didn ' t want her to drink a lot of caffeine. An interview on 5/23/19 at 1:12 pm with Nursing Assistant (NA) #1 revealed she worked with Resident #78 routinely and believed she was a diabetic, but other than that she wasn ' t aware of any diet restrictions. She stated the resident loved coffee and requested 2 cups with her meals. NA #1 added the resident drank her coffee black. She explained the kitchen sent the coffee out to the units in insulated pitchers and the NAs poured it for the residents. NA #1 stated she thought the coffee was decaffeinated, but she really wasn ' t sure. She added the NAs went by what was on the resident ' s meal card and she wasn ' t aware that Resident #78 wasn ' t supposed to have	F 808	daily during Daily Clinical rounds to ensure that all new orders are reflected on the tray card. Dietary staff will read and accurately prepare the tray for therapeutic diets. All Dietary Staff were re-educated as of 6/20/19 by the Dietary Manager on the importance of following therapeutic diets and tray accuracy. Staff not available for the training will not be allowed to work until training is complete. All newly hired dietary staff will be re-educated regarding therapeutic diets at the time of hire. 4) Monitoring: The Dietary Manager or Assistant Dietary Manager will audit one meal per day x one week, Monday through Friday, beginning on 6/20/19 for accuracy of tray cards and therapeutic diets, then one time per week x 3 weeks. These audits will continue on a monthly basis x 3 months. The Dietary Manager will compile a report of the findings of these audits for the Quality Assurance and Performance Improvement (QAPI) committee monthly x 4 months. The Quality Assurance and Performance Improvement (QAPI) committee will make changes the plan as necessary.	

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F 808	Continued From page 67 caffeine or artificial sweetener. An interview on 5/23/19 at 1:14 pm with Nurse #6 revealed she was the nurse for Resident #78. She stated the resident was a diabetic and was not supposed to use regular sugar. She added she was not aware of any other diet restrictions for the resident. Nurse #6 stated the resident loved coffee and drank several cups with each meal. An interview on 5/23/19 at 1:17 pm with the DM revealed Resident #78 was on an RCS, NAS diet and she liked coffee. She stated the facility used regular coffee. The DM added the resident also received iced tea with her lunch and dinner meal which was not decaffeinated. The DM stated she was not aware the resident was supposed to avoid caffeine and artificial sweeteners. She explained because the resident was on an RCS diet she would receive artificial sweetener with each meal. An interview on 5/23/19 at 3:25 pm with the Administrator revealed it was her expectation that physicians ' orders were followed.	F 808	Effective 6/20/19, the facility Administrator and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction to ensure the facility attains and maintains substantial compliance.	
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 from local producers, subject to applicable State and local laws or regulations.	F 812		6/20/19

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F 812	Continued From page 68 (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, record review and staff interviews the facility failed to allow dishware to air dry; ensure foods were covered, labeled and dated when stored, maintain the hood vents, walk-in refrigerator fans and ceiling and dish room floor in a clean sanitary manner and propped open the back door, which allowed flies to enter the kitchen. The facility additionally failed to ensure temperatures for the dish machine were documented at the required temperatures. This was evident in 2 of 2 kitchen observations. Findings Included: 1. An observation of the kitchen on 5/19/19 at 9:10 am revealed the following: a. The walk-in refrigerator contained a pan of macaroni and cheese that was dated 4/19/19, a pan of cooked apples that was not dated or covered, 5 plates of salad that were not dated and heads of l ettuce that were wilted with brown edges. b. The dry storage room contained a bag of grits that was open to the air and not dated. c. 6 of 6 vent hoods located over the cooking equipment that were covered in a film of dust and	F 812	1)Measures for residents affected: The container of Macaroni and Cheese that was incorrectly dated 4/19/19 instead of 5/19/19 was discarded on 5/19/19. The pan of cooked apples was discarded as of 5/19/19. The 5 plates of salad were prepared on 5/19/19, they were not discarded. They were served as planned on 5/19/19. The heads of lettuce were discarded as of 5/19/19. The bag of grits were discarded as of 5/19/19. The hood vents were cleaned as of 6/17/19. The dishroom floor was cleaned as of 5/19/19. The kitchen door was closed after this was brought to the attention of the	

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F 812	Continued From page 69 grease. d. The floor in the dishwasher area was noted with a dark black film. e. The back door to the kitchen was propped open with a chair and flies were observed coming into the kitchen. An interview on 5/19/19 at 9:20 am with the Assistant Dietary Manager (ADM) revealed she had only been working at the facility for one week. She stated she had not had time to check the walk-in refrigerator to check the dates of the foods because she was assisting the dietary staff with their work. The ADM explained she had propped the back door open to take the trash out and when she returned to the kitchen she had to assist the staff on the breakfast tray line and had forgotten to close the door. She added the door should not have been propped open because it did allow flies to come into the kitchen. 2. An observation of the kitchen on 5/22/19 from 11:20 am through 12:55 pm revealed the following: a. 27 of 27 meal trays were stacked together wet on the serving line ready for lunch service. b. 14 of 14 plastic plate bases were stacked together wet on a cart ready for lunch service. c. 26 of 26 plastic bowls were stored in a bin and observed to be wet and have food particles on them. d. 9 of 9 scoop type plates were stored wet on the serving line ready for lunch service. e.The ceiling and 2 fans present in the walk-in refrigerator had a black, mold like substance covering both fans and the adjacent section of the ceiling. f. The dish machine temperature sanitizer record dated May 2019 revealed 5/1/19 through	F 812	Assistant Dietary Manager. The door has been closed unless staff are entering or exiting since 5/19/19. Meal trays, plastic plate bases, plastic bowls, scoop plates, were dried as of 5/22/19 after washing and prior to the next meal service. The ceiling of the walk in refrigerator and the 2 fans in the walk in refrigerator were cleaned as of 6/20/19. The dishmachine temperatures have been taken correctly and documented correctly beginning on 6/20/19. 2) Measures for residents potentially affected: A sanitation audit was performed by the Consultant Dietician to include all areas of the kitchen as of 6/17/19. 100% of Dietary staff have been educated as of 6/20/19 by the Dietary Manager regarding the importance of maintaining a sanitary kitchen. This training included: Labeling and dating all foods for storage, discarding outdated foods, the importance of discarding brown lettuce, the importance of keeping the walk in refrigerator clean, the parameters for the dish machine temperatures, the need to keep the dish room floor clean, the need to report when the hood vents appear dirty, the mandate to keep the back door closed unless entering and exiting, the mandate to properly store dishes in order	

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F 812	Continued From page 70 5/21/19 the wash temperatures were recorded from 90 to 170 degrees and the rinse temperatures were recorded from 120 to 165 degrees. An interview with the ADM on 5/22/19 at 11:50 am revealed when she checked the dish machine rinse temperatures they had run between 120 to 140 degrees. An interview with the Dietary Manager (DM) on 5/22/19 at 11:55 am revealed the facility had a company that came in and cleaned the hood filters and she believed they had cleaned the filters a month or so ago. She stated all the dishware should be allowed to air dry before being stored or placed on the serving line for meal service. The DM explained the meal trays should have been stacked on the tray line or placed in the meal carts to air dry. She added the plate bases should have been left in the drying rack, the bowls should have been stored in dish machine racks and the scoop plates should have been inverted to allow them to air dry. The DM stated the walk-in cooler fans and ceiling should be kept clean. She explained the dish machine used hot water to clean and sanitize the dishes. She added the wash temperature should be a minimum of 155 degrees and the rinse temperature should be a minimum of 180 degrees; she did not know why the staff were recording the wrong temperatures and they should notify her if the temperatures weren ' t correct. Review of the hood cleaning service report, provided by the DM, revealed the hoods were last serviced on 3/27/19.	F 812	to allow them to air dry. Staff not available for training will not be allowed to work until training is complete. All newly hired Dietary Staff will be educated regarding sanitation expectations, including the areas listed above at the time of hire. 4) Monitoring: The Dietary Manager or the Assistant Dietary will perform a sanitation check of the kitchen daily, Monday through Friday, x two weeks. This sanitation check will include cleanliness of walk in cooler, expiration dates of foods, ensuring that all opened packages are closed and labeled and dated. It will also include the dish machine temperatures and to ensure that dishes are stored to allow to air dry. They will also monitor to make sure that the back door is only open for entering and exiting. The sanitation checks will then be completed one time per week x two weeks, then continue weekly x 11 months. The Dietary Manager will compile a report of the findings of these audits and present to the Quality Assurance and Performance Improvement (QAPI) committee x one year. The Quality Assurance and Performance Improvement (QAPI) committee will make changes to the plan as necessary.	

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F 812	Continued From page 71 An interview on 5/23/19 at 3:39 pm with the Administrator revealed it was her expectation that all aspects of kitchen sanitation were maintained.	F 812	Effective 6/20/19, the facility Administrator and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction to ensure the facility attains and maintains substantial compliance.	
F 842 SS=C	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	F 842		6/20/19

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F 842	Continued From page 72 with 45 CFR 164.506; (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 observation, record review, and staff interviews the facility failed to provide consistent information regarding a resident's code status for	F 842	1) Measure for resident affected: Resident #33 code status was clarified as	

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F 842	Continued From page 73 one of two residents (Resident #33) reviewed for code status. Findings included: Resident #33 was originally admitted to the facility on 2/17/17 and was most recently readmitted on 1/5/19. Resident #33's cumulative list of diagnoses included: Chronic Obstructive Pulmonary Disease (COPD), cellulitis (a form of tissue infection), and generalized weakness. A review of the Minimum Data Set (MDS) assessments revealed the most recent MDS assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 3/31/19. The resident was coded as having been cognitively intact. A review completed of Resident #33's Electronic Medical Record (EMR) Face Sheet (a sheet providing information about the resident) revealed the resident's Advanced Directives were documented as Full Code (meaning that all life saving measures should be attempted). A review completed of Resident #33's medical record (Hard Chart) revealed the resident had a goldenrod stop sign Do Not Resuscitate (DNR) (meaning that life saving measures should not be attempted) sheet with an effective date of 1/3/19. Further review of the medical record revealed a physician's order dated 5/7/19 for an order of DNR. Review of the Face Sheet found in the hard chart revealed the resident's code status as Full Code. An interview was conducted on 5/22/19 at 8:51 AM with Nurse #1. Nurse #1 stated the code	F 842	of 5/22/19 to reflect that he wishes to be a □Do Not Resuscitate□ (DNR). The Electronic Medical Record was updated to reflect '□Check chart for code status□' as of 5/22/19. The resident□s □Golden Rod□ or Do Not Resuscitate (DNR) will be kept in the clinical record/□hard chart□ under the Advance Directive section of the chart. 2) Measure for residents with potential to be affected: An audit of 100% of resident□s Advance Directives was completed as of 6/20/19 by the Medical Records Director. Each Electronic Medical Record has been updated as of 6/17/19 to reflect '□Check chart□ in the Advance Directives section'. The Advance Directives or Do not Resuscitate(DNR) or full code status will be kept in the resident□s clinical record/hard chart□ under the Advance Directives section. There were no other residents identified as having conflicting information regarding code status during the audit. 3) Systemic Changes: Effective 6/20/19 newly admitted residents will have □"Check chart□" in the Advance Directive section of the Electronic Medical Record to avoid conflicting or outdated information to be reflected there. 100% of Nurses and the Medical Records Director have been educated by the	

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F 842	Continued From page 74 status for Resident #33 was not available on the Resident's Medication Administration Record (MAR). The nurse stated she checked his EMR and on the face sheet the resident's code status was a Full Code. The nurse stated there should be a duplicate of the face sheet in the chart as well. The nurse stated she did not know who would update the resident's face sheet in the event a resident's code status were to change. An interview and observation were conducted on 5/22/19 at 8:57 AM with Unit Manager (UM) #2. The UM stated a resident's code status was changed when the doctor writes the physician's order. The UM stated she did not believe a resident's code status was on the resident's Face Sheet, but a resident's code status was entered as a physician's order. She stated after it was entered as a physician's order the resident's code status would come up on the resident's MAR. Review of the Resident 33's hard chart revealed an observation of a physician's order for the resident to be a DNR and the resident's face sheet had the resident as a Full Code. The UM stated the advanced directives on the resident's face sheet were wrong and the resident was a DNR. The UM then entered an order for the Resident to be a DNR and she stated that would show up on the Resident's MAR. The UM further stated she was going to make the resident's advanced directives on the Face Sheet match immediately as DNR. During an interview conducted on 5/23/19 at 1:24 PM the Administrator stated a resident's code status had been being put in the resident's hard chart, the actual DNR. She stated the facility staff involved with a resident's code status needed to be education on entering a resident's code status	F 842	Director of Nursing, the Assistant Director of Nursing or the Administrator as of 6/20/19 regarding this new procedure. Staff who were not educated will not be allowed to work until they are educated. Newly hired Nurses or Medical Records staff will be educated at the time of hire. 4) Monitoring: Effective 6/20/19 during morning clinical meeting (Includes: Director of Nursing, Assistant Director of Nursing/Staff Development Coordinator, B-Side Unit Coordinator, Social Services Director, Assessment Coordinator, Dietary Manager, A-side Unit Coordinator), new orders will be reviewed for code status changes and verified to be in the residents chart under the Advanced Directives section. The Medical Records Director will audit new admissions x one month to ensure that the code status is correctly reflected in the resident□s clinical record/hard chart under the Advance Directives section. These audits will continue thereafter, monthly x 11 months. The Medical Records Director will compile a report to the Quality Assurance and Performance Improvement (QAPI) committee monthly x 12 months. The Quality Assurance and Performance Improvement committee will make	

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F 842	Continued From page 75 into the EMR. She further stated it was her expectation for a resident's code status match to a single document.	F 842	changes to the plan as necessary. Effective 6/20/19, the facility Administrator and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction to ensure the facility attains and maintains substantial compliance.	
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out	F 849		6/20/19

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at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical

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supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the

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resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:
(A) The most recent hospice plan of care specific to each patient.
(B) Hospice election form.
(C) Physician certification and recertification of the terminal illness specific to each patient.
(D) Names and contact information for hospice personnel involved in hospice care of each patient.
(E) Instructions on how to access the hospice's 24-hour on-call system.
(F) Hospice medication information specific to each patient.
(G) Hospice physician and attending physician (if any) orders specific to each patient.
(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff

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F 849	Continued From page 79 furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on record review, family and staff interviews the facility failed to follow a physician ' s order to arrange for palliative care. This was evident for 1 of 1 resident reviewed for hospice (Resident #89). Findings Included: Resident #89 was admitted to the facility on 4/6/19 and diagnoses included cerebral vascular accident, chronic kidney disease, dysphagia and legal blindness. Review of a physician ' s order dated 4/26/19 stated for Resident #89 to have palliative care. Review of a hospice and palliative care discharge dated 4/26/19 for Resident #89 stated the resident would be discharged from hospice care on 4/26/19 to access her part A benefits. Review a significant change minimum data set (MDS) dated 4/27/19 for Resident #89 did not identify the resident as having a condition or chronic disease that may result in life expectancy of less than 6 months and did identify the resident had impaired cognition.	F 849	1) Measure for residents affected: Resident #89's orders were carried out as of 6/20/19 to provide Palliative Care Services. 2) Measure for resident with potential to be affected: An audit of 100% of orders for Hospice and Hospice Palliative Care services was conducted as of 6/20/19 by the Medical Records Director to ensure that all orders for Hospice and Palliative Care have been carried out. 3) Systemic Change: Effective 6/20/19 Nurses will notify the Social Services Director of new orders for Hospice or Palliative Care. The Social Services Director or Assistant Social Services Director will follow through with that order by contacting Hospice/Palliative Care to notify them of the referral. 4) Monitoring:	

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F 849	Continued From page 80 An interview on 5/23/19 at 10:44 am with the Social Worker (SW) revealed Resident #89 no longer received hospice services and was now receiving rehab services. She stated hospice was discontinued on 4/26/19 because the resident ' s family wanted to see if she could participate in therapy. The SW added the resident now received palliative care services and the palliative care nurse came to see the resident and documented their visits. Review of the medical record for Resident #89 revealed no documentation or evidence of palliative care visits. A phone interview on 5/23/19 at 11:00 am with the facility contracted hospice and palliative care services revealed Resident #89 was not currently receiving any palliative care services. An interview on 5/23/19 at 11:43 am with the responsible party / family member for Resident #89 revealed she was under the impression that when hospice was discontinued the resident would receive palliative care. She stated she had mentioned this to one of the facility nurses (could not recall who), but the resident still hadn ' t received any palliative care visits. The family member added she would like to have the palliative care visits to have another set of eyes looking at the resident ' s overall health condition. A follow-up interview on 5/23/19 at 1:32 pm with the SW revealed she wasn ' t aware Resident #89 wasn ' t receiving palliative care services. She stated when an order was written for hospice or palliative care the nurses would let her know so she could set up the services. The SW	F 849	Effective 6/20/19 the Social Services Director or Social Services Assistant will check physician□s orders during morning clinical rounds, Monday through Friday to ensure that all Hospice and Palliative orders are followed through on. Orders will be checked on Monday for the weekend. The Social Services Director and the Social Services Assistant as well as licensed nurses were educated by the Director of Nursing, The Assistant Director of Nursing or the Administrator as of 6/20/19 on the importance of following through with physician□s orders for Hospice and Palliative Care services. All newly hired Social Services staff and Licensed Nurses will be educated on this at the time of hire. The Social Services Director will compile a report on the findings of these audits for the Quality Assurance and Performance Improvement committee monthly x 3 months, then quarterly x 9 months. The Quality Assurance and Performance Improvement committee will make changes to the plan as necessary. Effective 6/20/19, the facility Administrator and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction to ensure the facility attains and maintains substantial compliance.	

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F 849	Continued From page 81 explained she remembered when the resident went off hospice she was supposed to transition to palliative care. She added she believed she contacted palliative care and never heard anything back from them. An interview on 5/23/19 at 3:16 pm with the Administrator revealed it was her expectation that physician orders were followed.	F 849		
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility's Quality Assurance and Performance Improvement committee (QAPI) failed to maintain implemented procedures and monitor these interventions the committee put into place in April 2018. This was	F 865	1) Measures for affected residents: The Quality Assurance and Performance Improvement (QAPI) for grievances was updated and re-initiated for monitoring through the QAPI committee effective	6/20/19

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F 865	Continued From page 82 for 1 recited deficiency which was originally cited on 4/7/2018 (F585) during the recertification/complaint survey and on the current recertification/complaint survey on 5/23/2019 (F585). The continued failure of the facility during the two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance and Performance Improvement Program. The findings included: This tag is cross referred to: F585 Based on record review, resident interview, and staff interviews the facility failed to record a grievance for 1 of 3 residents reviewed for misappropriation of personal property (Resident #85). During the recertification and complaint investigation survey of 4/7/2018, the facility was cited for failure to record a grievance and failed to provide a written grievance summary for 1 of 4 residents reviewed for grievances (Resident #48). The Administrator was interviewed on 5/23/2019 at 5:24 PM and she reported the QAPI committee met monthly and quarterly and concerns were brought for review by the grievance process and trends in incident reports. The Administrator reported it was her expectation if the facility was cited during a survey, they put a process in place to prevent a repeat citation in the future. The Administrator further reported the laundry department was not completing grievance forms for missing clothing.	F 865	6/20/19. 2) Measures for residents with potential to be affected: An audit of 100% of QAPIs related to surveys from April 2018 to current was performed by the Administrator as of 6/20/19 to ensure that all areas have been through the committee and either discontinued related to substantial compliance achieved or are continuing in order to achieve substantial compliance. The Administrator was re-educated as of 6/20/19 by the Regional Clinical Director regarding the facility QAPI plan and the importance of following the QAPI plans in place until substantial compliance is achieved. 3) Systemic Change: The QAPI committee will evaluate each identified area for continuation or discontinuation monthly until a pattern of compliance is achieved. A pattern of compliance is demonstrated in the following manner: Must demonstrate that the action items are resolved by lack of further episodes, concerns or instances of the areas identified. The Rehabilitation Director will audit QAPI plans one time quarterly to ensure that all reporting and monitoring activities are	

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F 865	Continued From page 83	F 865	completed as per plan. The Rehabilitation Director will compile a report to the Quality Assurance and Process Improvement (QAPI) committee one time quarterly x one year. The Quality Assurance and Performance Improvement committee will make changes to the plan as necessary. Effective 6/20/19, the facility Administrator and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction to ensure the facility attains and maintains substantial compliance.	
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interviews from staff, the facility failed to have a safe, functional environment by allowing an extension cord (drop cord) to be utilized to provide power to an air mattress in 1 of 20 rooms (Room 209-1) reviewed for environment. Findings included: An observation conducted during a round on 5/22/19 at 4:27 PM revealed the resident in 209-1 had an air mattress pump which was being	F 921	1) Measure for residents affected: The air mattress pump for the resident in room 209 was replaced with a pump with a longer cord as to eliminate the need for an extension cord as of 6/20/19. 2) Measure for residents with potential to be affected: An audit of 100% of resident rooms was completed as of 6/20/19 by the	6/20/19

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F 921	Continued From page 84 supplied power via an extension cord. The extension cord traveled down the left side of the resident's bed to the foot of the bed and was plugged into the operating air pump which was hanging on the footboard. An observation conducted during a round on 5/23/19 at 2:49 PM with the District Housekeeping Manager revealed the resident in 209-1 had an air mattress pump which was being supplied power via an extension cord. The extension cord traveled down the left side of the resident's bed to the foot of the bed and was plugged into the operating air pump which was hanging on the footboard. An observation conducted during a round on 5/23/19 at 2:49 PM in conjunction with an interview with the Maintenance Director (MD) revealed the resident in 209-1 had an air mattress pump which was being supplied power via an extension cord. The extension cord traveled down the left side of the resident's bed to the foot of the bed and was plugged into the operating air pump which was hanging on the footboard. The MD stated he was unaware of the use of the extension cord in room 2019-1. The MD further stated extension cords were only to be used in the instance of an emergency and it was not an emergency. The MD stated he would remove the extension cord and ensure the pump for the air mattress was properly plugged into a receptacle without the use of an extension cord. During an interview with the Administrator conducted on 5/23/19 at 4:56 PM she stated it was her expectation for extension cords to be only utilized in an emergency situation.	F 921	Maintenance Director to ensure that no other extension cords were in place. During this audit there were no other extension cords found. All other equipment audited were placed near a receptacle or had cords of sufficient length to reach the receptacle. 3) Effective 6/20/19 the Central Supply Coordinator upon ordering equipment will check to ensure that cords are long enough for operation without extension cords. All staff, including the Maintenance Director and Central Supply Coordinator were re-educated regarding the use of extension cords only in emergency situations by the Director of Nursing and/or the Assistant Director of Nursing as of 6/20/19. Any staff member not re-educated will not be allowed to work until the re-education is complete. All newly hired staff will be educated at the time of hire that extension cords are only allowed during emergency situations. 4) Monitoring: The Maintenance Director will audit 5 rooms per day x two weeks for the use of extension cords. These audits will then continue on 5 rooms per week x two weeks. The audits will then continue for 5 rooms per month x 11 months. The Maintenance Director will compile a	

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F 921	Continued From page 85	F 921	report on the findings of these audits monthly for the Quality Assurance and Performance Improvement (QAPI) committee x one year. The Quality Assurance and Performance Improvement committee will make changes to the plan as necessary. Effective 6/20/19, the facility Administrator and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction to ensure the facility attains and maintains substantial compliance.	