STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345252	A. BUILDING _____ B. WING _____	C 06/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARSAW HEALTH & REHABILITATION CENTER	**214 LANEFIELD ROAD WARSAW, NC 28398**

(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 06/11/19 through 06/14/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #BV2U11.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation survey began June 11, 2019 and went through June 14, 2019. On June 24, 2019 additional information was obtained and the exit date was extended to 6/24/19. There were 8 allegations substantiated out of 19.	F 000		
F 570 SS=C	Surety Bond-Security of Personal Funds CFR(s): 483.10(f)(10)(vi) §483.10(f)(10)(vi) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to have a surety bond sum that was greater than the balance in the residents' fund account and failed to make the residents individually or in aggregate the obligee. This deficient practice had the potential to affect 91 of 91 residents in the nursing home. Findings included: The Business Office Manager (BOM) provided the posted transactions to the bank from June 3, 2019 through June 13, 2019. The highest balance during that period of time was $92,578.39 on June 3, 2019. The surety bond	F 570	Kissito Healthcare shares the state□s focus on the health, safety and well being of facility residents. Although the facility does not agree with some of the findings and conclusions of the surveyors, we have implemented a plan of correction to demonstrate our continuing effort to provide quality care to our residents. F 570 A general purpose rider dated 6/13/2019 indicated the rider recognizes resident at Warsaw Health and Rehab as the obligee in the amount of $100,000.	7/16/19

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

Electronically Signed | 07/04/2019

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F 570	Continued From page 1 along with the Continuation certificate was reviewed. The Continuation Certificate was initiated 12/31/2018 and ended 12/31/2019. It revealed the State of North Carolina was designated as the obligee. It indicated the surety bond was in the sum of $80,000. On 6/13/19 at 10:06 AM, the Business Office Manager said she received the bonds and kept them in a binder. The BOM referred to the owner's Account Manager for the amount of the bond and the obligee designation. On 6/13/19 at 10:32 AM, the Account Manager for the owner was interviewed by phone. She said the bond was based on the average balance in the residents' fund account according to the insurance company. She said her boss determined how much to cover. On 6/13/19 at 11:01 AM, the Chief Financial Officer was interviewed by phone. He said, "We always used the average." He said, "We can get it corrected." A short time later on 6/13/19, the Business Office Manager provided a General Purpose Rider dated June 13, 2019. The Rider indicated, "this bond recognizes Residents in the Aggregate of Warsaw Health and Rehabilitation as Obligee in the amount of $100,000.	F 570	Current residents in the center have the potential to be affected. Business Office staff was educated by the Chief Executive Officer/designee on the requirement to have a surety bond greater than the balance in the resident fund accounts and the residents are to be the oblige individually or in aggregate. The Chief Administrative Officer(CAO)/designee to monitor the surety bond on a weekly bases to ensure the amount of the surety bond is greater than what is in the resident fund account. The results will be reported to the monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists. The Chief Administrative Office(CAO)/Director of Nursing(DON)are responsible for the implementation of the plan of correction. Thanks	
F 584 SS=B	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	F 584		7/16/19

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F 584	Continued From page 2 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 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 interview, staff interview and observation the facility failed to maintain a safe,	F 584	1) a. no action was taken for the holes in the bathroom doors for rooms #1, 2, and	

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F 584	Continued From page 3 clean, comfortable, homelike environment: (1) hole in 3 of 17 bathroom doors (Room #1, #2, #12), (b) 2 foot by 3 foot bedroom ceiling stain in 1 of 17 bedrooms (Room # 14), (c) bathroom scrapes along the lower portion of the wall across from the toilet (Room #12). (2) (a) two of two upholstered side chairs in the activity/dining room on the skilled hall were dirty and worn, (b) two door frames going into the activity/dining room were scarred, (c) wall in the bathroom for room 65 had a long horizontal scrape along the lower portion of the wall and old moisture stain on the popcorn ceiling above Bed B, (d) the outer wall in room 76 had dried stains on the wall next to the bed (e) the commode in room 76 would not clear the contents when flushed (f) the bathroom wall in room 72 was scarred. (3) cigarette butts were randomly discarded over the gazebo, patio, grounds, and grass of 1 of 1 smoking areas (Locked Unit). The findings included: 1.a. Observation on 6/11/19 at 12:40 PM revealed holes in 3 bathroom doors (Room #1, #2, and #12). Observation with the Maintenance Director (MD) on 06/13/19 at 10:00 AM revealed holes in 3 bathroom doors (Room #1, #2, and #12). He said these were caused by the hallway door hitting the bathroom door when opened. He said the three bathroom doors would need to be repaired. He said the facility repairs had been brought up as an issue for months. He said they considered remodeling the facility, once the building was sold. b. Observation on 06/11/19 at 12:40 PM revealed a 2 foot by 3 foot water stained bedroom ceiling, where the popcorn had fallen off (Room #14). Observation with the Maintenance Director (MD)	F 584	12. During the survey. However, repairs to the holes in the bathroom doors will be completed by 7/16/19. b. No action was taken for the ceiling strain in the bathroom of room #14 during the survey. However, repairs to the ceiling in the bathroom will be completed by 7/16/19. c. No action taken for the scrapes along the lower portion of the wall across from the toileting room #2 during the survey. However, the repairs to the wall will be completed by 7/16/19. d. Two upholstered chairs in the activity/dining room on the skilled hall were discarded during the survey. e. No action was taken for the long scape horizontal scape along the lower part of the wall or for the moisture strain on the popcorn ceiling above Bed B in room in room #65 during the survey. However, the repairs to the wall and the ceiling will be completed by 7/16/19. f. No action taken during the survey for the dried strains on the wall next to the bed in room #76. The strains will be removed from the wall in room #76 by 7/16/19. g. The commode in room #76 was fixed so the contents now flush. h. No action for the scarred bathroom wall in room #76 during the survey. However,	

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F 584	Continued From page 4 on 06/13/19 at 10:00 AM revealed the ceiling in room #14 was in the same condition. He said he was aware of the ceiling water stain in room #14 for over a month. He said he did not have the ceiling in room #14 repaired because he did not have a budget, and that the contractor they hired to repair the ceiling had been out of town for a month. He said they were looking for another contractor that was willing to repair the ceiling in room #14. c. Observation on 6/13/19 at 10:00 AM revealed the wall in the bathroom for room 12 had multiple long horizontal scrapes along the lower portion of the wall across from the toilet. Observation with the Maintenance Director on 6/13/19 at 10:00 AM revealed the bathroom wall was scraped from a wheel chair. He said the scrapped bathroom wall would need to be repaired. An interview was conducted with the Administrator on 06/14/19 at 1:20 PM. The Administrator stated it was his expectation for the facility's physical environment to be intact and maintained. In addition, the Administrator stated it was his expectation if maintenance issues were discovered by a staff member, a work order for the maintenance department would be completed. Upon maintenance being made aware of the identified maintenance issue through the work order, the maintenance department would be able to complete the necessary repairs. However, he stated he was not allocated the needed requested needed budget by his corporate office necessary to make facility repairs. 2. a. Observation on 6/11/19 at 12:48 PM revealed two of two upholstered side chairs in the	F 584	the wall in the bathroom will be repaired by 7/16/19. i. Cigarette butts were cleaned from the gazebo, patio, grounds and grass outside the locked unit. The Maintenance Director was educated by the Regional Director of Maintenance on routine maintenance of the building. Current residents in the center have the potential to be affected. The Maintenance Director and Environmental Supervisor were educated by the Regional Director of Maintenance on cleaning the above mentioned areas. Housekeeping staff was educated to clean the cigarette butts on the patio and maintenance will clean the cigarette butts from the ground and the gazebo. Facility staff will be educated on the maintenance log and documenting areas that need repair on the log. Maintenance Director will be educated on the maintenance log and checking it 5x weekly for needed repairs. The CEO/designee will via direct observation five times weekly to ensure there are no cigarette butts on the patio/ grounds/ gazebo. In addition the CEO/designee will do a visual check throughout the facility for areas needing attention and repair as well as review of the maintenance logs five times weekly. Maintenance Director will monitor the log 5x weekly for any needed repairs.	

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F 584	Continued From page 5 activity/dining room on the skilled hall were dirty and worn. Observation with the Maintenance Director on 6/14/19 at 10:35 AM revealed the chairs were in the same condition. He said the chairs had been brought up as an issue by the Social Worker a couple of weeks ago. He said they considered removing the chairs, but since the nursing home did not have replacement furniture, they decided the chairs could be steam cleaned. The chairs had not been cleaned. b. Observation on 6/11/19 at 12:48 PM revealed the two door frames going into the activity/dining room were scarred. Observation with the Maintenance Director on 6/14/19 at 10:35 AM revealed the door frames were in the same condition. He said he had painted the walls in the room approximately two months ago. He said that getting the funds to buy paint was challenging because the budget was tight. c. Observation on 6/11/19 at 10:15 AM revealed the wall in the bathroom for room 65 had a long horizontal scrape along the lower portion of the wall and old moisture stain on the popcorn ceiling above Bed B. Observation with the Maintenance Director on 6/14/19 at 10:35 AM revealed the bathroom wall was scraped from the wheel chair. He said he would need to touch it up with a primer. d. Observation on 6/11/19 at 1:16 PM revealed the outer wall in room 76 had dried stains on the wall next to the bed. Interview with Housekeeper #1 on 6/13/19 at 12:51 PM revealed she was aware the resident spits on the wall all of the time. She said we clean daily with disinfectant. She said the wall had not been cleaned today. The floor had been mopped. On 6/14/19 at 1:35	F 584	The results will be reported to the monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. The CAO/DON are responsible for implementation of the plan of correction.	

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PM, the housekeeper assigned to the skilled unit said she was aware of the resident spitting on the wall. She showed how she cleaned up the wall. Interview with the Interim Dietary Manager/Housekeeping Supervisor on 6/14/19 at 9:57 AM revealed he was not aware of the resident spitting on the wall and said if no one tells him, he would not know. He said there is a deep clean schedule and said room 76 was done on June 3, 2019.

e. Observation on 6/11/19 at 1:16 PM revealed the commode in room 76 would not clear the contents when flushed. During the observation, Resident #37 said, the commode would flush, but it would not go down. On 6/13/2019 at 12:06 PM, stool was observed in the toilet. On 6/13/19 at 12:10 PM, Nurse Aide #6 said the toilet "stays messed up." Observation with the Interim Dietary Manager/Housekeeping Supervisor on 6/14/19 at 9:44 AM revealed the raised toilet seat with stool. Observation with the Maintenance Director on 6/14/19 at 10:35 AM revealed the toilet had been repaired. "We plunged and used snake." He was aware of the problem and stated that the residents put too much paper in the toilet.

f. Observation on 6/11/19 at 10:35 AM revealed the bathroom wall in room 72 was scarred. Observation with the Maintenance Director on 6/14/19 at 10:35 AM revealed the contractor that supplies hand soap had just replaced soap dispensers throughout the facility. The wall was damaged from where the old soap dispenser was removed.

3. On 06/11/19 at 11:44 AM the locked unit smoking area was observed. There were a multitude of randomly discarded cigarette butts on the wooden floor of the gazebo, on the

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sidewalk from the gazebo to the patio, in the landscaped plant area between the sidewalk and the building, on the grassy area bordering the patio, and on the concrete patio itself. On the patio there was a red container with a step on mechanism for opening that was for the disposal of cigarette butts. Next to that was an approximately waist high thin spherical container with a round broad base that was for the disposal of cigarette butts.

In an observation on 06/12/19 at 2:47 PM the cigarette butts were still strewn across the smoking area. There were two ash trays full of cigarette butts and rain water. The two containers that were meant for cigarette butt disposal were still on the patio.

In an observation on 06/13/19 at 8:46 AM there had been no change in the appearance of the locked unit smoking area except the addition of more cigarette butts on the ground.

In an interview on 06/13/19 at 9:05 AM the Maintenance Director stated he picked up any paper that was on the locked unit smoking area, but that housekeeping was responsible for cleaning up the cigarette butts.

In an observation and interview on 06/13/19 at 9:12 AM the Housekeeping Supervisor was asked to accompany the surveyor to the locked unit's smoking area. After looking at the area he indicated that it was the responsibility of the locked unit's housekeeper to remove the smoking debris from the concrete pad of the patio and that he could see it had not been done. He stated it was not the housekeeping departments responsibility to remove the cigarette butts from

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F 584	Continued From page 8 the grass, from the gazebo, from inside the planter, or from the sidewalk. The Housekeeping Supervisor stated that staff also used the locked unit's smoking area and should discard their cigarette butts in the proper containers and not throw them on the ground. In an interview on 06/13/19 at 9:21 AM Housekeeper #2 stated she did not know she was supposed to clean the patio in the locked unit's smoking area. In an interview on 06/13/19 at 10:46 AM the Administrator stated that he expected the housekeeping department to clean the patio cement block of smoking debris and the maintenance department to remove the smoking debris from the grass, gazebo, sidewalk and planters. In a follow-up interview on 06/14/19 at 3:30 PM the Administrator stated that he expected smoking materials to be discarded in the proper receptacles. He indicated that if a cigarette butt was extinguished by throwing it on the ground the staff member that was supervising the smoking area should pick it up and dispose of it in the provided containers.	F 584		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The	F 623		7/16/19

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facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;

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F 623	Continued From page 10 (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is	F 623		

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F 623	Continued From page 11 the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff and Ombudsman interviews the facility failed to provide written notice to the Ombudsman for 1 of 3 residents (Resident #62) who was transferred to the hospital. Findings included: Review of the facility Admission/Discharge List revealed that Resident #62 was transferred to the hospital on 03/24/19 and again on 04/10/19. In a telephone interview on 06/13/19 at 8:38 AM the Ombudsman stated she had not received any information from the facility regarding transfers or discharges. In an interview on 06/13/19 at 8:43 AM Social Worker (SW) #1 stated she had faxed the required information to the Ombudsman office but was unable to provide documentation or a fax cover sheet to show that it had been done. In a follow-up interview on 06/13/19 at 9:00 AM the Ombudsman stated that faxes came in to the office and the administrative assistant distributed them. She indicated that she received the required information from other facilities. In an interview on 06/14/19 at 3:35 PM the Administrator stated he expected the SW to send	F 623	F623 No action was taken due to the timeframe it already passed. Current residents in the center have the potential to be affected. The CEO/Social Services Director was educated by the Chief Nursing Officer/designee on the process for notification to the Stare Ombudsman when residents are transferred/discharged from the center. Notifications are are to faxed weekly to the State Ombudsman. The CEO/designee what audit each transfer and/or discharge from the center to ensure the paperwork was completed and notification to the state ombudsman has been completed weekly. The results will be reported to the monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis.	

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F 623	Continued From page 12 a monthly list by e-mail to update the Ombudsman of the facility transfers and discharges.	F 623	The CAO/DON are responsible for the implementation of the plan of correction.	
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to provide a nutritional supplement ordered by the physician for weight maintenance and a protein supplement ordered by the physician for a low albumin level for 1 of 6 sampled residents (Resident #8) reviewed for nutrition. Findings included: 1a. Resident #8 was re-admitted to the facility on	F 692	F692 Resident #8 is now receiving the nutritional supplement and protein supplement as ordered by the MD. And audit of current physician orders for current residence in facility was completed to insure that the MD orders	7/16/19

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F 692	Continued From page 13 09/14/16 and had diagnoses of brain cancer, vascular dementia without behaviors and Parkinson's disease. Resident #8's June 2019 Physician's orders revealed a current order, that was initiated on 09/17/16, for the resident to receive one cup of ice cream with breakfast and lunch. Resident #8's weight record revealed that on 12/03/18 her weight was 138 pounds. The quarterly Minimum Data Set (MDS) dated 03/25/19 revealed Resident #8 had a short-term memory problem and was severely impaired in cognitive skills for daily decision making. Resident #8 needed set up help and supervision for meals. Resident #8 weighed 132 pounds and had no swallowing disorders. Resident #8's most recent Care Plan revealed she was at risk for altered nutritional status. Interventions included to monitor weights and report any significant weight loss or gain, to provide the diet as ordered, and to consider nutritional supplements as indicated. Review of the Meal Intake record revealed that Resident #8 averaged 76-100% consumption of the recorded meals from 04/01/19-06/13/19. Review of Resident #8's weight record revealed that on 06/03/19 her weight was 125 pounds. In an observation on 06/13/19 at 8:40 AM Resident #8 was in the dining room eating breakfast. She did not receive ice cream on her breakfast tray. The resident's meal card, served with this resident's meal tray, did not list ice	F 692	and medication administration record match. The audit also included a review of diet and meal tickets for accuracy. Licensed nurses/nursing leadership was educated by the Regional Director of Clinical services/designee on ensuring MD orders are transcribed onto the medication ministration record accurately. In addition the education d included ensuring that the dietary communication slip has been sent to the dietary department for any nutritional supplements that are to be served on the resident’s meal tray. The Director of Nursing/designee will review new orders during clinical meeting five times weekly to ensure accuracy of transcribing physician orders. In addition diet orders and/or supplements will also be reviewed during the daily clinical meeting 5x per week to ensure that communication has been sent to the dietary department. The results will be reported to the monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. CAO/DON will be responsible for implementation of the plan of correction.	

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cream as something that needed to be provided with this meal.

In an observation on 06/13/19 at 12:29 PM Resident #8 was in the dining room eating lunch. The dessert for the day was unable to be served so ice cream was substituted instead. Resident #8 did receive a cup of ice cream for dessert but did not receive a second cup of ice cream as a supplement as ordered. Resident #8's meal card, served with the resident's meal tray, did not list ice cream as a supplement that was to be served with the meal. Resident #8 did eat the ice cream that was provided as dessert.

In an interview on 06/13/19 at 1:25 PM Registered Dietician (RD) #1 stated that she had been working in the facility since mid-February and had not yet assessed Resident #8. She indicated she had not been contacted regarding Resident #8's nutritional status. She indicated that if a supplement, such as ice cream, was ordered it needed to be given to the resident. She indicated that if ice cream was served as a dessert then a second serving should be served as the supplement. She stated that any supplements that were to be served with meals needed to be on the meal card so that dietary would know to serve it. RD #1 indicated that if the facility had any concerns regarding a resident's nutritional status they could call her for a consultation.

In an interview on 06/13/19 at 1:45 PM the Interim Dietary Manager stated that supplements were listed on resident meal cards so that the dietary aides could put them on the meal trays. He indicated that if the supplements were not on the meal cards then dietary would not put them on

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the trays. The Interim Dietary Manager verified that Resident #8 did not have ice cream listed as a supplement on her meal card.

In an interview on 06/13/19 at 2:15 PM Dietary Aide #2 stated that she worked in the facility six days a week and until that morning no one had ever requested ice cream for Resident #8. Dietary Aide #2 indicated that she did not put ice cream on Resident #8's breakfast and lunch meal trays because it was not noted on her meal card to be served with these meals.

In an interview on 06/13/19 at 2:35 PM Nursing Assistant (NA) #1 stated that an aide was assigned to oversee the dining room at meal times. When the meal trays were served to residents it was the responsibility of the person providing the meal to make sure the residents got what was listed on their meal cards. She indicated that if an item was not on the meal card then the resident would not receive the item because they would not know the resident was supposed to get it. NA #1 stated she had never requested ice cream for Resident #8. She indicated that Resident #8 ate well, and that breakfast was her best meal.

In an interview on 06/14/19 at 10:10 AM NA #5 stated that he was the one who usually oversaw the dining room. He indicated that he would pass out the meal trays, checking the meal cards to be sure the residents got the correct diet, and any supplements that were listed on the cards. NA #5 stated it was his responsibility to let the other aides know how much of their meals and supplements the residents consumed. He indicated that if a supplement was not listed on the meal card he would not know that the resident

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was supposed to receive it.

In an interview on 06/13/19 at 2:54 PM the Administrator stated that in January 2019 the company that managed the dietary department quit and took their computer and the records with them. He indicated that the facility had to recreate the resident meal cards and felt that the ice cream supplement for Resident #8 was left off when this happened.

In an interview on 06/14/19 at 3:40 PM the Director of Nurses (DON) stated that nutritional supplements which were ordered with meals needed to be on resident's meal cards. She indicated that if they were not then no one would know they were supposed to be given. The DON indicated that when the previous dietary company left it may have caused the discrepancy on Resident #8's meal card. The DON stated that she expected residents to receive nutritional supplements if ordered especially if there was a weight loss. She indicated that she would expect the RD to evaluate a resident's weight loss on assessment and to discuss any suggested interventions with her.

In a telephone interview on 06/24/19 at 6:02 PM Physician #2 stated that every dementia patient has weight loss. She indicated that she did not feel that Resident #8's 13 pound weight loss was detrimental to her. She indicated that Resident #8 was 97 years old and that her weight loss was expected.

1b. Resident #8 was re-admitted to the facility on 09/14/16 and had diagnoses of brain cancer, vascular dementia without behaviors and Parkinson's disease.

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Review of Resident #8's laboratory results dated 01/18/19 revealed an albumin level of 2.6 g/dL (gram/deciliter). A normal level of albumin was between 3.4 g/dL and 5.0 g/dL.

Review of the Telephone Orders dated 01/19/19 revealed an order for active liquid protein 30 cc (cubic centimeters) to be given by mouth every day for low albumin.

Review of the January and February 2019 Medication Administration Records (MARs) revealed the order for the liquid protein with a handwritten administration time. The liquid protein had been administered daily beginning on 01/01/19 through 02/28/19.

Resident #8's most recent Care Plan revealed she was at risk for altered nutritional status and interventions included to monitor weights and report any significant weight loss or gain, to provide the diet as ordered, and to consider nutritional supplements as indicated.

Review of Resident #8's laboratory results dated 02/08/19 revealed an albumin level of 2.9 g/dL showing a slight increase in the albumin level.

Review of the March, April, May and June 2019 MARs revealed the order for active liquid protein was written on each of the MARs, but the administration time was missing. There were no nurse initials signifying that the active protein had been given in March, April, May or June 2019.

Review of the quarterly Minimum Data Set (MDS) dated 03/25/19 revealed Resident #8 had a short-term memory problem and was severely

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impaired in cognitive skills for daily decision making.

In an interview on 06/12/19 at 5:05 PM Nurse #4 verified that there were no initials on the liquid protein order on the June 2019 MAR. She indicated that there was no time written for the administration of the liquid protein and that she had not administered the liquid protein or clarified the order to see what time it should have been administered. She stated that she believed the order had been overlooked by the nurses since there was no administration time and that the liquid protein had not been administered.

Review of Resident #8's laboratory results dated 06/13/19 revealed an albumin level of 3.4 g/dL showing an increase in the albumin to a normal level.

In an interview on 06/13/19 at 1:25 PM Registered Dietician (RD) #1 stated she had worked at the facility since mid-February and had not assessed Resident #8 yet. She indicated that if a protein supplement had been ordered then it should have been administered.

In an interview on 06/13/19 at 1:57 PM Nurse #2, who did the first check on the June 2019 MAR, stated that the first check was performed to make sure everything was correct for the safety of the resident. She stated when she did the June 2019 MAR check she did not notice the nurse's initials signifying the supplement was administered and the time for administration of the liquid protein was not on the MAR. She indicated the timing of the order had just been missed. Nurse #2 stated she had worked with Resident #8 during the months in question and that she had not

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administered the liquid protein as ordered.

In an interview on 06/13/19 at 4:24 PM Nurse #4 stated that when the new MARs were printed a double check was performed to make sure all the orders from the previous month's MAR were included. If orders had been discontinued, added, changed, or were missing information it was the responsibility of the nurse doing the first check to correct the discrepancies and make sure the new MAR was complete. Nurse #4 stated a second nurse would then check over the new MAR and if any discrepancies were found it was that nurse's responsibility to correct them. She verified that she had performed the second check on Resident #8's April MAR and did not know how they missed that the nurse did not initial the liquid protein was administered and there was no time for administration of the liquid protein noted on the MAR.

In an interview on 06/14/19 at approximately 9:40 AM Nurse #1, who worked with Resident #8 in March, April, May and June 2019, verified that the order for the liquid protein appeared on the MAR but that the liquid protein had not been administered. She indicated that because there was no time for administration the order had been overlooked and that she had not administered the liquid protein.

In an interview on 06/14/19 at 3:45 PM the Director of Nursing (DON) stated she expected protein supplements to be given as ordered because a low albumin level could cause muscle wasting and skin breakdown. She stated that the missing time for the liquid protein should have been found during the daily medication administration and during the nurses end of the

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F 692	Continued From page 20 month double check of the MARs. The DON stated that the administration time of the liquid protein should have been 8:00 AM and would have been the responsibility of the day shift nurse.	F 692		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to keep unattended medications secured by leaving them on top of the back	F 761	F761 Medications were immediately removed	7/16/19

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F 761	Continued From page 21 counter of the nurse's station (Skilled Hall) for 1 of 3 nurse's stations observed. Findings included: In an observation on 06/14/19 at 10:26 AM five bubble pack cards of medication were seen on top of the back counter of the Skilled Hall nurse's station. The nurse's station was located at the front of the building at the intersection of two hallways and the front door foyer. The half door to the nurse's station was open. A staff member was seen walking past the nurse's station, but no staff was attending the medications. After approximately 40 seconds Nurse #2 rushed into the nurse's station through the open half door. In an interview on 06/14/19 at 10:27 AM Nurse #2 verified that the five bubble pack cards of medication that had been left on the counter contained 32 omeprazole 20 mg (milligrams) pills (used to decrease the acid in the stomach), 15 donepezil 10 mg pills (used to treat dementia), 3 omeprazole 20 mg pills, 26 amlodipine 5 mg pills (used to treat high blood pressure), and 14 atorvastatin 10 mg pills (used to treat high cholesterol). Nurse #2 stated she had pulled the medications in preparation for a resident discharge and had only been out of the nurse's station for a minute. In an interview on 06/14/19 at 3:45 PM the Director of Nursing (DON) indicated medications should be secured at all times and not left on top of counters or medication carts for the safety of the residents.	F 761	from the back counter of the skilled nurse's station. Current residents in the center have the potential be affected. Licensed nurses have been educated by the regional director of clinical services/designee on ensuring medications are secured and no medications are kept on the back counter of any nurse's station. The Director of Nursing/designee will via direct observation monitor to ensure medications are secured five times weekly. The results will be reported to the monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. CAO/DON are responsible for implementation of the plan of correction.	
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2)	F 801		7/16/19

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F 801	Continued From page 22 §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to	F 801		

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F 801	Continued From page 23 November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on staff interviews, the facility did not employ a qualified director of food and nutrition services with the competencies and skills required to carry out food and nutrition services for 91 of 91 sampled residents. Findings included:	F 801	F801 Interim CDM was contracted with a start date of 7/5/2019 for 30 days. The permanent CDM has been hired and will start 7/27/2019.	

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F 801	Continued From page 24 On 6/11/19 at 9:49 AM the person in charge of the Dietary Department said he was the Interim Dietary Manager (IDM) and was also over housekeeping services. He stated he had been in the role of IDM for a couple of months. He was not a certified dietary manager (CDM) and the dietitian came to the facility a couple of times a month. On 6/13/19 at 7:57 AM, the Interim Dietary Manager stated he used to be the cook in dietary and the nursing home had been without a full time dietary manager for a couple of months. On 6/14/19 at 9:57 AM, the Interim Dietary Manager said he was carrying out two positions. He said, "I just rotate both positions back and forth. In an interview on 6/14/19 at 9:57 AM, the IDM explained he had been short of staff in the dietary department. One person was on medical leave, four people (2 cooks and 2 diet aides) quit a couple of weeks ago. He said that was the reason for the areas not being cleaned. He said, "I am only man and I am doing 2 positions. I just rotate both positions back and forth (between dietary and housekeeping)." On 6/13/19 at 11:15 AM, the IDM said the nursing home had just switched over to a new food vendor. He was not using the diet spread sheets because the Registered Dietitian had not signed them yet. They were using the new menu for about 3 months. They use the diet requisition form and tray card slip from the computer. On 6/13/19 at 1:45 PM the registered dietitian stated she had consulted at the nursing home since mid-February or early March. She visited two times a month and was hired to do clinical work. She said, "It's been a bumpy trail." On her second visit the previous dietary manager (not certified) quit. On her third visit to the home all of	F 801	Current residents in the center have the potential to be affected. The Chief Administrative Officer was educated by the Chief Nursing Officer/designee to sure there is a Qualified CDM in place to carry out the food and nutritional services of the center. The Chief Administrative Officer/designate will ensure there is a qualified CDM in the center to carry out the food nutritional services of the center. The results will be reported to the monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. CAO/DON are responsible for implementation of the plan of correction.	

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F 801	Continued From page 25 the diet spread sheets were missing and menus disappeared. They are trying to recruit for a new food service director who is a certified dietary manager. The Interim Dietary Manager was working part-time in the kitchen and part-time in housekeeping. She said things do not operate here like they do in the other buildings where she consults. In her other buildings, she completes assessments, follows wounds, residents on tube feedings and those with significant weight changes. At this facility the IDM hands me a notebook with diet orders. I don't think the system can give a weight report. On 6/14/19 at 1:28 PM, the administrator was interviewed. He stated he had been employed since May 16, 2019. He said when he walked into this building, he discovered the nursing home did not have a Certified Dietary Manager. He said the Interim Dietary Manager (IDM) was doing both functions - Dietary Manager and Housekeeping Supervisor. The Administrator confirmed the Interim Dietary Manager had switched back and forth between the two positions. The administrator concluded that one person cannot run both departments. He said the former DM's contract was lost due to payment issues. He also indicated the facility was in the process of recruiting a CDM.	F 801		
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	F 812		7/16/19

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F 812	Continued From page 26 approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to maintain clean surfaces in the kitchen and hold food on the tray line at a temperature of 135 degrees or higher. This had the potential to affect 91 of 91 residents in the facility. Findings included: 1. A brief tour of the kitchen was conducted on 6/11/19 at 9:49 AM with the Interim Dietary Manager (IDM). The dry storage room had one vent in the ceiling. There was a grayish, black substance around the vent. The IDM said, "When it gets moist, it starts turning colors." During the same tour, the wall behind the dish machine was noted to be covered with a black substance. Review of the undated cleaning schedule revealed the dish machine area should be cleaned every day. Dusting and wiping walls was also on the cleaning schedule.	F 812	F812 Kitchen services were clean including the wall behind the dishwasher in the dish room. The vent in the dry storage area was clean. Dietary staff was educated on the appropriate temperatures of food to hold at least 135°. Current resident in the center have the potential to be affected. Dietary staff was educated by the Regional Director of Clinical Services/ designee on the Cleanliness of the kitchen including surfaces, dry storage vent, and area behind the dishwasher in the dish room. Education also included	

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F 812	Continued From page 27 An interview was conducted on 6/14/19 at 10:29 AM with Diet Aide #1. She confirmed she washed dishes on 6/11/19. She said she had not noticed the black substance on the wall in the dish room. She said it probably needed to be cleaned every day. On 6/13/19 at 7:57 AM the IDM said the black substance was cleaned off of the wall in the dish room and in the dry storage room. The areas were observed clean at this time. A follow up interview with the IDM on 6/14/19 at 9:57 AM revealed when dietary staff run the dishwasher, the heat from the dishwasher makes the wall moist. He confirmed that Diet Aide #1 was assigned dishwashing during the morning of 6/11/19. The IDM explained he had been short of staff in the dietary department. He said one person was on medical leave, four people (2 cooks and 2 diet aides) quit a couple of weeks ago. He said that was the reason for the areas not being cleaned. He said, "I am only man and I am doing 2 positions. I just rotate both positions back and forth (between dietary and housekeeping)." 2. Temperatures of food being served from the tray line were taken on 6/13/19 at 8:05 AM with Cook #1 and the IDM. The items for the main menu (scrambled eggs, grits, pureed eggs, sausage, chopped sausage and pureed sausage) were all held at a temperature greater than 135 degrees (°) Fahrenheit (F). Two alternate items, oatmeal and boiled eggs were held below 135° F at 126°F and 121°F, respectively. A substituted item, hash browns, was held at 107° F. Cook #1 nor the IDM attempted to remove these items from the tray line for reheating.	F 812	instructions on regular cleaning schedule and assignments. Dietary staff was also educated on the appropriate temperatures of food to hold at least 135° The Chief Administrative Officer/designee will be via direct observation while making rounds in the kitchen three times weekly ensure cleanliness in addition to food temps will be taken by the CAO/designee three times weekly to ensure appropriate temps of food. The results will be reported to the monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. CAO/DON are responsible for implementation of the plan of correction.	

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F 812	Continued From page 28 During this observation Cook #1 said temperatures should be 160 - 170° F. She said if the food was not at the appropriate temperature, she would warm it back up. She said she had already served some oatmeal. A follow up interview with Cook #1 on 6/14/19 at 10:18 AM revealed she didn't pull the foods off of the line because she knew the steam table would keep it warm. She said she checked it (the temperature) later and it was okay. She said 5-6 people requested oatmeal and 4 people requested boiled eggs. On 6/13/19 at 8:24 AM, the IDM said food should be at 165 - 175° F after bringing it from the kitchen. He said, the cook should bring the temperature up if it is not at 165 - 175° F. A follow up interview with the IDM on 6/14/19 at 9:57 AM revealed Cook #1 was nervous and that is why she did not pull items less than 135° F from the tray line to reheat. On 6/14/19 at 1:28 PM, the administrator was interviewed. He had been employed at the building since May 16, 2019. He confirmed there had been turnover in the dietary staff and said he received four resignations from dietary staff last week. He also confirmed the IDM had switched back and forth from housekeeping responsibilities to dietary. He said they had advertised for a cook and dietary aide. New people were hired on 6/12/19.	F 812		
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced	F 814		7/16/19

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F 814	Continued From page 29 by: Based on observation and staff interview, the facility failed to have 1 of 2 dumpsters in good condition that would contain waste and leaks. Findings included: Two dumpster containers and a cardboard recycling container were located at the end of the facility parking area approximately 85 yards away from the kitchen's back door. The dumpsters were observed on 6/11/19 at 9:49 AM with the Interim Dietary Manager. One of the two dumpsters had a rusty hole at the bottom left hand side. A black bag was sticking out of the hole. The Interim Dietary Manager said it was used by housekeeping. He said he did not know if another container had been requested. On 6/13/19 at 07:57 AM another observation of the dumpster was made with the Maintenance Director. Plastic bags were sticking out of the rusty hole and flies were swarming around. The Maintenance Director said he would try and get a replacement dumpster. On 6/14/19 at 8:48 AM the dumpster was viewed with the administrator. The dumpster's rusted corner was approximately 12 inches x 4 inches. A bag was sticking out of the hole. The administrator said he was unaware of the dumpster's condition and his assistant would call and ask for a replacement.	F 814	F814 No action was taken during the survey. However a new dumpster has been ordered and will replace the dumpster in poor repair. Current residents in the center have the potential to be affected. The Director of Maintenance was educated by the Regional Director of Maintenance/designee on ensuring the dumpsters are in good working repair. The Chief Administrative Officer/designee will monitor the condition of the dumpsters on a weekly basis ensure they are in good repair. The results will be reported to the monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. CAO/DON are responsible for implementation of the plan of correction.	
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and	F 835		7/16/19

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F 835	Continued From page 30 efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and observation, the facility failed to have the financial resources and support of the owner to effectively and efficiently administer the facility in the areas of qualified director of food and nutrition services, laundry, housekeeping and dietary services, building maintenance, contracted services, office supplies, surety bond and dumpster. This deficient practice had the potential to affect 91 of 91 residents in the facility. Findings included: 1. This tag is cross referred to F 801. Based on staff interviews, the facility did not employ a qualified director of food and nutrition services with the competencies and skills required to carry out food and nutrition services for 91 of 91 sampled residents. The Registered Dietitian was interviewed on 6/13/19 at 1:45 PM. She said she had been consulting since mid-February to early March. She said she was hired to strictly do clinical nutrition work, but she had to carry out some administrative tasks as well. She explained that the former Dietary Manager who was not a certified dietary manager quit during her second visit to the nursing home. She said during her third visit to the nursing home, all of the diet spread sheets were missing and menus disappeared. She concluded that there was no infrastructure from the owner of the business. The Administrator was interviewed on 6/14/19 at 1:28 PM. He said the food service/housekeeping	F 835	F835 A receivership hearing was conducted on June 20, 2019. Kissito healthcare was placed into the facility as the operator during the receivership. Interim CDM starts on July 5, 2019. The acting Dietary Manager has returned to his previous role as the housekeeping supervisor. Repairs, contracted services, office supplies, surety bond and dumpster have been addressed with he management staff and resources supplied. Environmental repairs will be completed no later than July 16, 2019. New Dumpster has been ordered to replace the dumpster in poor repair. The dumpster will be delivered by July 16, 2019. A current updated surety bond in the amount of $100,000 was given to the survey team on 6/23/19 by the current licensed operator. Current residents in the center have potential be affected. The Chief Administrative Officer/	

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F 835	Continued From page 31 contract was lost because of non-payment. He said the contract company pulled out their line staff first and then they pulled out their dietary and housekeeping management staff. The contract company also took their computer and he had to purchase a computer for the dietary department the next day. He replaced laundry staff. He said four people left in dietary for more pay a short time ago. He said the Registered Dietitian had left in April due to nonpayment. Since that time she was paid and she came back and has been visiting two times per month. 2. The Administrator was interviewed on 6/14/19 at 1:28 PM. He said he had to beg today for a check for laundry detergent. He explained that he had a contractor for three different parts of the facility, dietary (dish and cleaning supplies), laundry and housekeeping. He said the first issue the nursing home (NH) had with the contractor was when there was a pest problem. He said the NH could not get the contractor out here when the facility had an initial suspicion of the problem. It was not until the Health Department became involved that the bill was paid. The Health Department came on 5/24/19. Accounts receivable sent an urgent email saying the Health Department was here and we had to have pest control services. The Administrator said the NH sprayed for pests themselves. The supplier came on 5/30/19. He added the contractor was going to repossess the dishwasher for lack of funds. He concluded, "We have to beg for everything." 3. Rounds were made with the Maintenance Director on 6/14/19 10:35 AM. He said that	F 835	management staff have been addressed on the new management company and the mechanism to get needed resources. Facility will have a corporate presence in the center on a weekly basis both of the operations side as well as clinical side until it is determined a smooth transition with concerns and needs are addressed in a timely manner The results will be reported to the monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. CAO/DON will be responsible for implementation of plan of correction.	

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F 835	Continued From page 32	F 835		

funding was challenging and there was no working budget for paint and supplies needed to maintain the building. He said the facility considered discarding the soiled and worn upholstered side chairs in the activity room, but stated the facility did not have much furniture, so they planned to steam clean the chairs. Regarding scarred walls and door frames, he said he usually purchased matching wall paint from a specific vendor, but did not have funds to get paint.

Review of a statement dated 6/3/19 from the referenced vendor revealed previous unpaid balances.

The Administrator was interviewed on 6/14/19 at 1:28 PM. He said there is an issue getting paint. Our money runs out quickly. He said, "I have a kitchen that was flooding. I got a drain kit. I had to get an auger to snake drains because I could not get a plumber. I can't get a plumber if we have a problem.

4. The Administrator was interviewed on 6/14/19 at 1:28 PM. He shared a letter dated 5/31/19 from the rehabilitation services' collections company. It indicated the facility's account was severely past due. He said that if the facility had a contract with any entity, the facility was behind in payments. This included the pharmacy company and the physician. On 6/11/2019 at 11:56 AM, the administrator said the only people getting paid were the facility staff.

5. The Administrator was interviewed on 6/14/19 at 1:28 PM. He said we do not have a vendor for office supplies. He said he bought the supplies, submitted a receipt and got reimbursed from

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F 835	Continued From page 33 petty cash funds. He said he had about $1000 per week. He said he had to beg for a check last week and added that the money was already spent. Review of petty cash transmittals for the weeks of 5/28/19 and 6/10/19 revealed purchases for office supplies, vehicle inspection, registration and air conditioning repair, tools to fix drains, postage and other miscellaneous needs. Observation during the interview revealed a staff person getting the last pack of copy paper. 6. This tag is cross referred to F 814. Based on observation and staff interview, the facility failed to have 1 of 2 dumpsters in good condition that would contain waste and leaks. 7. This tag is cross referred to F 570. Based on record review and staff interview, the facility failed to have a surety bond sum that was greater than the balance in the residents' fund account and failed to make the residents individually or in aggregate the obligee. This deficient practice had the potential to affect 91 of 91 residents of the nursing home.	F 835		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records.	F 842		7/16/19

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F 842	Continued From page 34 §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (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	F 842		

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	345252	A. BUILDING _____ B. WING _____	C 06/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARSAW HEALTH & REHABILITATION CENTER	214 LANEFIELD ROAD WARSAW, NC 28398

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 35 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 record review and staff interviews the facility failed to maintain complete and accurately documented medical records for 1 of 27 Residents (Resident #61) whose medical records were reviewed. Findings included: Resident #61 was admitted to the facility on 04/23/19 with diagnoses that included hypertension, left bundle branch block, heart failure, atrial septal defect, automatic implantable cardiac defibrillator, Type 2 diabetes mellitus and stroke. Review of the physician orders for Resident #61 for the month of May, 2019 revealed the following orders: 1. Amiodarone 400 mg take one tablet by mouth three times a day until 05/02; check pulse prior and hold if < 60; 2. Amiodarone 400 mg take one tablet by mouth twice a day 05/03 - 05/16; check pulse prior and hold if < 60. Both orders were printed on the MAR. The first order was to stop after 05/02/19. The second order that was to begin on 05/03/19 was for the same	F 842	F842 No action was taken because the time frame had already passed. A 30 day look back audit was completed to ensure that medications were transcribed accurately to the medication ministration record from the physician orders. Licensed nurses will be were educated by the Regional Director of Clinical services/designee on accurately transcribe orders to the medication ministration record from the physician orders. The Director of Nursing/designee will review new orders in the clinical meeting five times weekly to ensure that medications have been transcribed	

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F 842	Continued From page 36 medication and dose but she was to receive the medication only twice a day instead of three times a day. Review of the MAR for Resident #61 revealed Nurse #2 initialed she administered Amiodarone 400 mg at 8:00 PM on 05/01/19 to the resident who had a pulse rate of 80. Further down on the MAR on 05/01/19 she initialed that she administered a second dose of Amiodarone 400 mg at 8:00 PM to the resident who had a pulse rate of 77. Again on 05/02/19, Nurse #2 initialed she administered Amiodarone 400mg at 8:00 PM to the resident who had a pulse rate of 74 and further down on the MAR she initialed that she administered a second dose of Amiodarone 400 mg at 8:00 PM to the resident who had a pulse rate of 80. On 05/01/19 and 05/02/19 Nurse #1 documented that she administered a dose of Amiodarone 400 mg at 8:00 PM (which was not scheduled to begin until 05/03/19) in addition to the dose that was scheduled for 05/01/19 and 05/02/19. During an interview with Nurse #2 on 06/13/19 at 2:30 PM she revealed she was 100% sure that she had not given the resident 800 mg of Amiodarone at 8:00 PM on either 05/01/19 or 05/02/19. She stated she did not know why she signed both orders indicating she gave the resident two 400 mg Amiodarone tablets at 8:00 PM on both days. She also reported she could not explain why she had recorded different pulse rates for the same time and date on both days. She commented she did not always take a manual radial pulse rate on a resident when passing medications. She stated she sometimes used the value recorded by the aide who had taken vital signs or used a reading off an oxygen	F 842	accurately onto the medication administration record. The results will be reported to the monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. CAO/DON are responsible for implementation of the plan of correction.	

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F 842	Continued From page 37	F 842		

saturation machine (pulse ox). She reiterated during the interview that she was positive she had not given the medication twice in error but had only documented incorrectly.

An interview was conducted with the Director of Nursing on 06/13/19 at 3:00 PM. She stated that she had already contacted the pharmacy and obtained a manifest of when the Amiodarone for Resident #61 had been delivered to the facility. She reported she felt confident only one dose had been given on 05/01/19 at 8:00 PM but was unsure about the dosage administered to the resident on 05/02/19 at 8:00 PM. She concluded Nurse #2 had documented that the medication had been given twice but only gave it once as ordered. She commented that because the nurses were trained to administer medications then return to the MAR and sign off all the medications at once, the nurse probably just went down the MAR page and signed off everything that had an administration time of 8:00 PM on both days. She could not explain why different pulse rates had been recorded for the exact same times and dates. She reported she had started an in-service regarding medication errors and documentation. She stated she expected medications to be given as ordered by the physician and documented accurately.