DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345503 | A. BUILDING ______<br>B. WING ______ | 10/24/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **LIBERTY COMMONS NSG & REHAB CTR OF ROWAN COUNTY** | **4412 SOUTH MAIN STREET**<br>**SALISBURY, NC 28147** |

| (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 |
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| E 000 | Initial Comments<br><br>An unannounced Recertification survey was conducted on 10/21-24/2019. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #4V7G11. | E 000 | | |
| F 636<br>SS=F | Comprehensive Assessments & Timing<br>CFR(s): 483.20(b)(1)(2)(i)(iii)<br><br>§483.20 Resident Assessment<br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.<br><br>§483.20(b) Comprehensive Assessments<br>§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:<br>(i) Identification and demographic information<br>(ii) Customary routine.<br>(iii) Cognitive patterns.<br>(iv) Communication.<br>(v) Vision.<br>(vi) Mood and behavior patterns.<br>(vii) Psychological well-being.<br>(viii) Physical functioning and structural problems.<br>(ix) Continence.<br>(x) Disease diagnosis and health conditions.<br>(xi) Dental and nutritional status.<br>(xii) Skin Conditions.<br>(xiii) Activity pursuit.<br>(xiv) Medications.<br>(xv) Special treatments and procedures. | F 636 | | 11/19/19 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 11/14/2019 |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 636 | Continued From page 1<br>(xvi) Discharge planning.<br>(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).<br>(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.<br><br>§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.<br>(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.)<br>(iii)Not less than once every 12 months.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews the facility failed to complete a comprehensive assessment for 9 of 9 residents reviewed for completion of a comprehensive assessment within 366 days of the previous comprehensive assessment and within 14 days after admission to the facility (Resident #8, Resident #4, Resident #230, Resident #80, Resident #5, Resident #129, Resident #179, Resident #38, and Resident #36). | F 636 | The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of | |

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Findings included:

1. A. Resident #8 admitted to the facility on 10/17/12 and readmitted on 8/17/18. Her diagnoses were Dementia, Heart Failure, Hypertension, Chronic Kidney Disease, and Osteoarthritis.

A review on 10/23/19 of Resident #8's medical record revealed she was scheduled to have an Annual Minimum Data Set (MDS) Assessment with an ARD (Assessment Reference Date) of 9/9/19. The assessment was not completed or transmitted.

An interview with the MDS Nurse on 10/24/19 at 10:48 am revealed she had taken over the responsibility of Director of Nursing position and continued as of the MDS Nurse in June and July of 2019. She stated she did not have any assistance with the MDS Assessments during this time and had fallen behind and had not completed or transmitted Resident #8's Annual MDS Assessment with the ARD of 9/9/19. She stated there had also been an issue with the MDS software program and the corporate MDS Consultant had instructed her by email to not complete or transmit MDS Assessments until she notified her due to a software problem.

An interview with the Administrator on 10/24/19 at 5:55 pm revealed his expectation was the Minimum Data Set Assessments should be completed and transmitted in a timely manner per the direction of the RAI manual. He stated the MDS Nurse had been the interim Director of Nursing for 6 to 8 weeks in June and July 2019 and had not been able to keep up with the

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compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.
F 636 COMPREHENSIVE ASSESSMENT & TIMING
Corrective Action:
Resident #8. Annual Comprehensive Assessment, Assessment Reference Date (ARD) 9/9/2019. Completed, Submitted and Accepted on 10/29/2019 to the State Quality Improvement Evaluation System QIES system
Resident #4. Annual Comprehensive Assessment, Assessment Reference Date (ARD) 9/4/2019. Completed, Submitted and Accepted on 10/24/2019 to the State QIES system
Resident #230. Admission Comprehensive Assessment, Assessment Reference Date (ARD) 10/7/2019. Completed, Submitted and Accepted on 10/22/2019 to the State QIES system
Resident #80. Admission Comprehensive Assessment, Assessment Reference Date (ARD) 7/1/2019. Completed, Submitted and Accepted on 8/13/2019 to the State QIES system
Resident #5. Annual Comprehensive Assessment, Assessment Reference Date (ARD) 09/05/2019. Completed, Submitted and Accepted on 10/24/2019 to the State QIES system
Resident #129. Admission Comprehensive Assessment, Assessment Reference Date (ARD) 9/12/2019. Completed, Submitted and Accepted on 10/16/2019 to the State QIES system
Resident #179 Significant Change Comprehensive Assessment, Assessment

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Minimum Data Sets. The Administrator also stated he had received an email from the corporate office that indicated the facility should not complete or transmit MDS Assessments with and ARD of 10/1/19 or later until notified differently.

B. Resident #4 admitted to the facility on 9/7/18 with diagnoses of Hypertension, Arthritis, Hemiplegia, Anxiety, and Depression.

A review of Resident #8's medical record on 10/23/19 revealed an Annual MDS Assessment with an ARD of 9/4/19 had not been complete or transmitted.

During an interview on 10/23/19 at 4:06 pm the MDS Nurse stated she had taken over the responsibilities of MDS Nurse and Director of Nursing in June and July of 2019. She stated she did not have any assistance in either role and had fallen behind in the MDS Assessments. The MDS Nurse stated there had also been an issue with the MDS software program and the corporate MDS Consultant had instructed her by email to not complete or transmit MDS Assessments until she notified her due to a software problem.

An interview with the Administrator on 10/24/19 at 5:55 pm revealed his expectation was the Minimum Data Set Assessments should be completed and transmitted in a timely manner per the direction of the RAI manual. He stated the MDS Nurse had been the interim Director of Nursing for 6 to 8 weeks in June and July 2019 and had not been able to keep up with the Minimum Data Sets. The Administrator also stated he had received an email from the

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Reference Date (ARD) 10/22/2019. Completed, Submitted and Accepted on 11/15/2019 to the State QIES system
Resident #38. Admission Comprehensive Assessment, Assessment Reference Date (ARD) 7/12/2019. Completed, Submitted and Accepted on 8/7/2019 to the State QIES system
Resident #36. Admission Comprehensive Assessment, Assessment Reference Date (ARD) 7/16/2019. Completed, Submitted and Accepted on 8/12/2019 to the State QIES system

Identification of other residents who may be involved with this practice:
All current residents with Comprehensive Minimum Data Set (MDS) assessments due have the potential to be affected by the alleged practice. On 11/11/2019 through 11/14/2019 an audit was completed by the MDS Nurse consultant to ensure that the facility had conducted a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. Out of the 84 current residents, 8 number of residents did not have their comprehensive assessments completed within 14 calendar days after admission, excluding readmission in which there is no significant change in the resident's physical or mental condition and 4 number of resident did not have their Annual comprehensive assessments completed by timeframes. This assessments were completed by 11/15/2019.
Systemic Changes:

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| F 636 | Continued From page 4<br>corporate office that indicated the facility should not complete or transmit MDS Assessments with and ARD of 10/1/19 or later until notified differently.<br><br>C. Resident #230 admitted to the facility on 9/30/19 with diagnoses of Irritable Bowel Syndrome and digestive surgery.<br><br>A review of the medical record for Resident #230 on 10/23/19 revealed an Admission MDS Assessment with an ARD of 10/7/19 had been completed late and was transmitted late. A Submission Report from the Quality Improvement Evaluation (QEIS) Assessment Submission and Processing (ASAP) System (QIES ASAP) dated 10/22/19 revealed Resident #230's Admission MDS Assessment was submitted on 10/22/19 which was more than 14 days after the ARD of 10/7/19.<br><br>During an interview with the MDS Nurse on 10/23/19 at 4:06 pm she stated the Annual MDS Assessment with an ARD of 9/9/19 for Resident #230 was not completed until 10/22/19. The MDS Nurse stated she has been responsible for the Director of Nursing and the MDS Nurse positions during July 2019 and August 2019 without any assistance and she had not been able to keep the assessments completed. The MDS Nurse stated there had also been an issue with the MDS software program and the corporate MDS Consultant had instructed her by email to not complete or transmit MDS Assessments until she notified her due to a software problem.<br><br>An interview with the Administrator on 10/24/19 at 5:55 pm revealed his expectation was the | F 636 | On 11/12/2019 The Registered Nurse (RN) Minimum Data Set (MDS) Coordinator, Licensed Practical Nurse (LPN) Support nurses any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by the MDS nurse consultant.<br>The education focused on: The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.<br>OBRA-required comprehensive assessments include the completion of both the MDS and the CAA process, as well as care planning. Comprehensive assessments are completed upon admission, annually, and when a significant change in a resident's status has occurred or a significant correction to a prior comprehensive assessment is required. They consist of: Admission Assessment, Annual Assessment, and Significant Change in Status Assessment (SCSA)and Significant Correction to Prior Comprehensive Assessment (SCPA). The Admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day 1 if: this is the resident's first time in this facility, OR the resident has been admitted to this facility and was discharged return not anticipated, OR the resident has been admitted to this facility and was discharged return anticipated | |

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Minimum Data Set Assessments should be completed and transmitted in a timely manner per the direction of the RAI manual. He stated the MDS Nurse had been the interim Director of Nursing for 6 to 8 weeks in June and July 2019 and had not been able to keep up with the Minimum Data Sets. The Administrator also stated he had received an email from the corporate office that indicated the facility should not complete or transmit MDS Assessments with and ARD of 10/1/19 or later until notified differently.

D. Resident #80 was admitted to the facility on 6/12/19 and discharged on 8/15/19. His diagnoses included Chronic Kidney Disease, Diabetes, and Dementia.

A review of the medical record for Resident #80, a discharged resident, on 10/24/19 revealed an Admission MDS Assessment with an ARD of 7/1/19 was completed on 7/26/19. A Submission Report from the QIES ASAP System showed Resident #80's Admission MDS Assessment with an ARD of 7/1/19 was not completed and transmitted until 7/25/19. The Final Validation Report stated the assessment was completed more than 13 days after Resident #80's admission date and is late.

An interview with the MDS Nurse on 10/24/19 at 10:48 am revealed she had taken over the responsibility of Director of Nursing position and continued as of the MDS Nurse in June and July of 2019. She stated she did not have any assistance with the MDS Assessments during this time and had fallen behind and had completed or transmitted Resident #80's Admission MDS Assessment with the ARD of 7/1/19 more than 13

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and did not return within 30 days of discharge. The Annual assessment is a comprehensive assessment for a resident that must be completed on an annual basis (at least every 366 days) unless a SCSA or a SCPA has been completed since the most recent comprehensive assessment was completed. Its completion dates (MDS/CAA(s)/care plan) depend on the most recent comprehensive and past assessments' ARDs and completion dates.
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. Special treatments and procedures.(xvi) Discharge planning.(xvii) Documentation of summary information 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

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| F 636 | Continued From page 6<br>days after his admission date.<br><br>An interview with the Administrator on 10/24/19 at 5:55 pm revealed his expectation was the Minimum Data Set Assessments should be completed and transmitted in a timely manner per the direction of the RAI manual. He stated the MDS Nurse had been the interim Director of Nursing for 6 to 8 weeks in June and July 2019 and had not been able to keep up with the Minimum Data Sets. The Administrator also stated he had received an email from the corporate office that indicated the facility should not complete or transmit MDS Assessments with and ARD of 10/1/19 or later until notified differently.<br><br>2. A. Resident # 5 was admitted to the facility on 09/19/2017 with diagnoses that included muscle weakness, chronic pain, anemia, depression and dementia.<br><br>A review of the medical record of Resident # 5 was conducted on 10/24/2019 and revealed a comprehensive annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) set on 09/05/2019 was completed on 10/23/2019 and the MDS was accepted to the Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) System on 10/24/2019.<br><br>A review of the Final Validation Report for the facility dated 10/24/2019 included a warning: the assessment completed late more than 14 days after the ARD date. | F 636 | resident, as well as communication with licensed and non licensed direct care staff members on all shifts.<br>This in service was completed by 11/14/2019. Any MDS nurse (full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.<br>Monitoring:<br>To ensure compliance, The Director of Nursing and/or Minimum Data Set (MDS) Nurse Consultant will review weekly, 5 residents electronic records Minimum Data Set(MDS) assessment this could be either one of the following Comprehensive assessments (Admission Assessment, Annual Assessment, and Significant Change in Status Assessment and Significant Correction to Prior Comprehensive Assessment) to ensure that the comprehensive assessments are completed timely. This will be done be reviewing the validation reports and reviewing the warning message for each comprehensive assessment. This will be done on weekly basis to include the weekend for 12 weeks then monthly for 3 months. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate | |

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During an interview on 10/23/2019 at 4:06 PM the MDS Nurse stated she had taken over the responsibilities of MDS Nurse and Director of Nursing in June and July of 2019. She stated she did not have any assistance in either role and had fallen behind in the MDS Assessments. The MDS nurse stated there had also been an issue with the MDS software program and the corporate MDS Consultant had instructed her by email to not complete or transmit MDS Assessments until she notified her due to a software problem.

An interview with the Administrator on 10/24/2019 at 5:55 PM revealed his expectation was the Minimum Data Set Assessments should be completed and transmitted in a timely manner per the direction of the RAI manual. He stated the MDS Nurse had been the interim Director of Nursing for 6 to 8 weeks in June and July 2019 and had not been able to keep up with the Minimum Data Sets. The Administrator also stated he had received an email from the corporate office that indicated the facility should not complete or transmit MDS Assessments with and ARD of 10/01/2019 or later until notified differently.

B. Resident # 129 was readmitted to the facility on 09/05/2019 with diagnoses that included Alzheimer's disease, dementia, diabetes mellitus depression and anxiety.

A review of the medical record of Resident # 129 was conducted on 10/23/2019 and revealed a comprehensive admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) set on 09/12/2019 was completed on

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concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse.

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| F 636 | Continued From page 8<br>10/15/2019 and the MDS was accepted to the Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) System on 10/16/2019.<br><br>A review of the Final Validation Report for the facility dated 10/16/2019 included a warning: the admission assessment completed late more than 14 days after the ARD date and more than 13 days after the entry date.<br><br>During an interview on 10/23/2019 at 4:06 PM the MDS Nurse stated she had taken over the responsibilities of MDS Nurse and Director of Nursing in June and July of 2019. She stated she did not have any assistance in either role and had fallen behind in the MDS Assessments. The MDS nurse stated there had also been an issue with the MDS software program and the corporate MDS Consultant had instructed her by email to not complete or transmit MDS Assessments until she notified her due to a software problem.<br><br>An interview with the Administrator on 10/24/2019 at 5:55 PM revealed his expectation was the Minimum Data Set Assessments should be completed and transmitted in a timely manner per the direction of the RAI manual. He stated the MDS Nurse had been the interim Director of Nursing for 6 to 8 weeks in June and July 2019 and had not been able to keep up with the Minimum Data Sets. The Administrator also stated he had received an email from the corporate office that indicated the facility should not complete or transmit MDS Assessments with and ARD of 10/01/2019 or later until notified differently. | F 636 | | |

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3. a. Resident #179 was admitted to the facility on 12/10/2013 and her most recent readmission was dated 1/23/2017. Diagnoses for Resident #179 included cerebral vascular accident, dementia, anemia and anxiety.

The most recent quarterly Minimum Data set dated 4/4/2019 assessed her to be moderately cognitively impaired without behaviors.

The last annual MDS was completed 5/15/2018. A quarterly MDS was due 7/5/2019 but was not completed.

During an interview on 10/23/19 at 4:06 pm the MDS Nurse stated she had taken over the responsibilities of MDS Nurse and Director of Nursing in June and July of 2019. She stated she did not have any assistance in either role and had fallen behind in the MDS Assessments. The MDS Nurse stated there had also been an issue with the MDS software program and the corporate MDS Consultant had instructed her by email to not complete or transmit MDS Assessments until she notified her due to a software problem. The MDS nurse reported the annual for Resident #179 should have been completed by 5/16/2019.

An interview with the Administrator on 10/24/19 at 5:55 pm revealed his expectation was the Minimum Data Set Assessments should be completed and transmitted in a timely manner per the direction of the RAI manual. He stated the MDS Nurse had been the interim Director of Nursing for 6 to 8 weeks in June and July 2019 and had not been able to keep up with the Minimum Data Sets. The Administrator also

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| F 636 | Continued From page 10<br>stated he had received an email from the corporate office that indicated the facility should not complete or transmit MDS Assessments with and ARD of 10/1/19 or later until notified differently.<br><br>b. Resident #38 was admitted to the facility 7/5/2019 with diagnoses to include pressure ulcers, hypertension and diabetes. The most recent admission Minimum Data Set assessment dated 7/12/2019 assessed Resident #38 to be moderately cognitively impaired without behaviors. The admission MDS was completed on 8/6/2019.<br>The MDS nurse reported the admission MDS should have been completed by 7/26/2019.<br><br>The admission MDS was completed 8/6/2019.<br><br>An interview was conducted10/23/19 at 4:06 pm with the MDS Nurse stated she had taken over the responsibilities of MDS Nurse and Director of Nursing in June and July of 2019. She stated she did not have any assistance in either role and had fallen behind in the MDS Assessments. The MDS Nurse stated there had also been an issue with the MDS software program and the corporate MDS Consultant had instructed her by email to not complete or transmit MDS Assessments until she notified her due to a software problem. The MDS nurse reported the admission MDS for Resident #38 should have been completed 14 days after the ARD of 7/12/2019.<br><br>An interview with the Administrator on 10/24/19 at 5:55 pm revealed his expectation was the | F 636 | | |

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| F 636 | Continued From page 11 | F 636 | | |

Minimum Data Set Assessments should be completed and transmitted in a timely manner per the direction of the RAI manual. He stated the MDS Nurse had been the interim Director of Nursing for 6 to 8 weeks in June and July 2019 and had not been able to keep up with the Minimum Data Sets. The Administrator also stated he had received an email from the corporate office that indicated the facility should not complete or transmit MDS Assessments with and ARD of 10/1/19 or later until notified differently.

c. Resident #36 was admitted to the facility on 7/9/2019 with diagnoses to include hypertension, congestive heart failure and diabetes. The admission Minimum Data Set assessment dated 7/16/2019 assessed Resident #36 to be cognitively intact without behaviors.

The admission MDS assessment had an ARD of 7/19/2019 and was due by 7/30/2019 but was marked as completed 8/11/2019.

The MDS nurse was interviewed 10/23/19 at 4:06 pm and she stated she had taken over the responsibilities of MDS Nurse and Director of Nursing in June and July of 2019. She stated she did not have any assistance in either role and had fallen behind in the MDS Assessments. The MDS Nurse stated there had also been an issue with the MDS software program and the corporate MDS Consultant had instructed her by email to not complete or transmit MDS Assessments until she notified her due to a software problem. The MDS nurse reported the admission MDS for Resident #36 should have been completed on 7/30/2019.

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| F 636 | Continued From page 12<br><br>An interview with the Administrator on 10/24/19 at 5:55 pm revealed his expectation was the Minimum Data Set Assessments should be completed and transmitted in a timely manner per the direction of the RAI manual. He stated the MDS Nurse had been the interim Director of Nursing for 6 to 8 weeks in June and July 2019 and had not been able to keep up with the Minimum Data Sets. The Administrator also stated he had received an email from the corporate office that indicated the facility should not complete or transmit MDS Assessments with and ARD of 10/1/19 or later until notified differently. | F 636 | | |
| F 638 SS=F | Qrtly Assessment at Least Every 3 Months<br>CFR(s): 483.20(c)<br><br>§483.20(c) Quarterly Review Assessment<br>A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews the facility failed to complete and submit a Quarterly Minimum Data Set (MDS) Assessment within 14 days of the Assessment Reference Date (ARD) and every 92 days to the Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) System (QIES ASAP) for 16 of 17 Residents, Residents #7, #9, #12, #50, #79, #11, #23, #2, #10, #16, #67, #16, #18, #56, #3, #19.<br><br>Findings included: | F 638 | The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.<br>F 638 QRTLY ASSESSMENT AT | 11/19/19 |

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| F 638 | Continued From page 13<br>1. A. Resident #7 was admitted to the facility on 9/13/17 with diagnoses of hypertension, diabetes, parkinson's disease, depression and anxiety.<br><br>On 10/23/19 a review of Resident #7's medical record revealed she had a Quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 9/9/19 that had not been submitted to the Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) System (QIES ASAP). The assessment should have been completed by 9/22/19 (14 days after the ARD). Since the assessment had not been closed there was not a final validation report.<br><br>During an interview on 10/24/19 at 10:58 am the MDS Nurse stated she had not completed or transmitted the Quarterly MDS Assessment with an ARD of 9/9/19. She stated she had not been able to complete the MDS Assessment because she was responsible for the MDS Nurse and the Director of Nursing roles during June 2019 and July 2019 without any assistance.<br><br>B. Resident #9 was admitted to the facility on 1/9/15 with diagnoses of heart failure, hypertension, dementia, anxiety, and depression. A review of the medical record on 10/23/19 revealed Resident #9 had a Quarterly MDS Assessment with an ARD of 9/12/19. The Quarterly MDS Assessment with an ARD of 9/12/19 had not been transmitted to the QIES ASAP system and was late since it had not been completed within 14 days after the ARD.<br><br>On 10/24/19 at 10:58 am an interview with the MDS Nurse revealed she had fallen behind in | F 638 | LEAST EVERY 3 MONTHS<br>Corrective Action:<br>Resident #7 Quarterly Assessment Reference Date (ARD) 9/9/2019. Completed, Submitted and Accepted on ¬¬¬¬10/25/2019 to the State Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) system.<br>Resident #9 Quarterly Assessment Reference Date (ARD) 9/12/2019. Completed, Submitted and Accepted on ¬¬¬¬10/28/2019 to the State QIES ASAP system.<br>Resident #12 Quarterly Assessment Reference Date (ARD) 9/19/2019. Completed, Submitted and Accepted on 10/29/2019 to the State QIES ASAP system.<br>Resident #50 Quarterly Assessment Reference Date (ARD) 8/11/2019. Completed, Submitted and Accepted on 9/5/2019 to the State QIES ASAP system.<br>Resident #79 Quarterly Assessment Reference Date (ARD) 7/18/2019. Completed, Submitted and Accepted on 8/13/2019 to the State QIES ASAP system. Resident Discharged.<br>Resident #11 Quarterly Assessment Reference Date (ARD) 9/19/2019. Completed, Submitted and Accepted on 10/29/2019 to the State QIES ASAP system.<br>Resident #23 Quarterly Assessment Reference Date (ARD) 10/4/2019. Completed, Submitted and Accepted on 10/30/2019 to the State QIES ASAP system.<br>Resident #2 Quarterly Assessment | |

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| F 638 | Continued From page 14<br>with the MDS Assessments because she was responsible for the MDS Nurse and the Director of Nursing roles without any assistance.<br><br>C. Resident #12 was admitted to the facility to the facility o 9/19/19 with diagnoses of heart failure and dementia.<br>A review of the medical record for Resident #12 revealed she had a Quarterly MDS Assessment with an ARD of 9/19/19 that was not completed and had not been transmitted to the QIES ASAP system and was late since it had not been completed within 14 days after the ARD.<br><br>During an interview with the MDS Nurse on 10/24/19 at 11:06 am she stated she had not completed or transmitted the Quarterly MDS Assessment with an ARD of 9/19/19. The MDS Nurse stated she had responsible for the Director of Nursing Position and the MDS Nurse Position during June and July 2019 and had gotten behind on completing her MDS Assessments. She stated she had also been instructed by the Corporate Consultant MDS Nurse to not complete any of the September MDS Assessments because of a problem with the software the facility used.<br><br>D. Resident #50 was admitted to the facility on 5/11/19 with diagnoses of emphysema, asthma, and pressure ulcer.<br>On 10/23/19 a review of the medical record revealed Resident #50 had a Quarterly MDS Assessment with an ARD of 8/11/19 that was not completed until 9/4/19.<br><br>A review of the Final Validation Report provided by the MDS Consultant dated 10/24/19 for the Quarterly MDS Assessment with an ARD of | F 638 | Reference Date (ARD) 9/4/2019.<br>Completed, Submitted and Accepted on 10/24/2019 to the State QIES ASAP system.<br>Resident #10 Quarterly Assessment Reference Date (ARD) 9/15/2019.<br>Completed, Submitted and Accepted on 10/28/2019 to the State QIES ASAP system.<br>Resident #16 Quarterly Assessment Reference Date (ARD) 9/16/2019.<br>Completed, Submitted and Accepted on 10/29/2019 to the State QIES ASAP system.<br>Resident #67 Quarterly Assessment Reference Date (ARD) 8/28/2019.<br>Completed, Submitted and Accepted on 9/17/2019 to the State QIES ASAP system.<br>Resident #16 Quarterly Assessment Reference Date (ARD) 9/16/2019.<br>Completed, Submitted and Accepted on 10/29/2019 to the State QIES ASAP system.<br>Resident #18 Quarterly Assessment Reference Date (ARD) 9/20/2019.<br>Completed, Submitted and Accepted on 10/29/2019 to the State QIES ASAP system. Resident discharged.<br>Resident #56 Quarterly Assessment Reference Date (ARD) 8/16/2019.<br>Completed, Submitted and Accepted on 9/10/2019 to the State QIES ASAP system.<br>Resident #3 Quarterly Assessment Reference Date (ARD) 9/2/2019.<br>Completed, Submitted and Accepted on 10/24/2019 to the State QIES ASAP system. | |

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| F 638 | Continued From page 15<br>8/11/19 stated the assessment was submitted on 9/5/19 to the Quality Improvement Evaluation System Assessment Submission System (QIES ASAP) more than 14 days after the ARD and is a late assessment.<br><br>During an interview with the MDS Nurse on 10/24/19 at 10:58 am she stated she had fallen behind in completing and transmitting the MDS Assessments because she had been responsible for the MDS Nurse and the Director of Nursing roles without any assistance.<br>E. Resident #79 was admitted to the facility on 1/8/19 and deceased in the facility on 8/17/19. Her diagnoses included heart failure, hypertension, and osteoarthritis.<br><br>A review of Resident #79's medical record revealed a Quarterly MDS Assessment with an ARD of 7/18/19 that was not completed within 14 days of the Assessment Reference Date.<br><br>A review of the Final Validation Report provided by the MDS Consultant on 10/24/19 for the Quarterly MDS Assessment with an ARD of 7/18/19 revealed the assessment was completed more than 14 days after the ARD date and was a late assessment.<br><br>During an interview with the MDS Nurse on 10/24/19 at 10:58 am she stated she had fallen behind in completing and transmitting the MDS Assessments because she had been responsible for the MDS Nurse and the Director of Nursing roles without any assistance.<br><br>An interview with the Administrator on 10/24/19 at 5:55 pm revealed his expectation was the MDS Assessments should be completed and | F 638 | Resident #19 Quarterly Assessment Reference Date (ARD) 9/5/2019. Completed, Submitted and Accepted on 10/24/2019 to the State QIES ASAP system.<br>Identification of other residents who may be involved with this practice:<br>All current residents with Quarterly Minimum Data Set (MDS) assessments due have the potential to be affected by the alleged practice. On 11/11/2019 through 11/15/2019 an audit was completed by the MDS Nurse consultant to ensure that the facility had conducted Quarterly Review assessment of each resident's. Out of the 84 current residents, 0 number of residents did not have their quarterly review assessments completed within 92days since the ARD of the previous OBRA Quarterly Review Assessment or ARD of previous comprehensive assessment. This assessments were completed and submitted by 11/15/2019.<br>Systemic Changes:<br>On 11/12/2019 The Registered Nurse (RN) Minimum Data Set (MDS) Coordinator, Licensed Practical Nurse (LPN) Support nurses any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by the MDS nurse consultant.<br>The education focused on: The facility must conduct initially and periodically a Quarterly Review Assessment of each resident's functional capacity.<br>OBRA-required quarterly review assessments are to be completed within | |

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transmitted in a timely manner per the direction of the RAI manual. He stated the MDS Nurse had been the interim Director of Nursing for 6 to 8 weeks in June and July 2019 and had not been able to keep up with the Minimum Data Sets. The Administrator also stated he had received an email from the corporate office that indicated the facility should not complete or transmit MDS Assessments with and ARD of 10/1/19 or later until notified differently.

2. a. Resident #11 was admitted to the 12/7/2018 with diagnoses to include hypertension, glaucoma and collapsed vertebra. The most recent quarterly Minimum Data Set assessment dated 6/16/19 assessed Resident #11 to be cognitively intact without behaviors.

The quarterly MDS dated 9/19/2019 was "in progress" and not completed.

During an interview on 10/23/19 at 4:06 pm the MDS Nurse stated she had taken over the responsibilities of MDS Nurse and Director of Nursing in June and July of 2019. She stated she did not have any assistance in either role and had fallen behind in the MDS Assessments. The MDS Nurse stated there had also been an issue with the MDS software program and the corporate MDS Consultant had instructed her by email to not complete or transmit MDS Assessments until she notified her due to a software problem. The MDS nurse reported the quarterly assessment for Resident #11 should have been completed by 10/14/2019.

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92days since the ARD of the previous OBRA Quarterly Review Assessment or ARD of previous comprehensive assessment, or significant Correction to Prior Quarterly Assessment ( ARD of any of the mentioned assessments + 92 calendar days). The MDS completion date (item Z0500B must be no later than 14days after the ARD (ARD + 14 calendar days).
This in service was completed by 11/14/2019. Any MDS nurse (full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.
Monitoring:
To ensure compliance, The Director of Nursing and/or Minimum Data Set(MDS) Nurse Consultant will review weekly, 5 residents electronic records Minimum Data Set(MDS) Quarterly assessments to ensure that the assessments are to be completed within 92days since the ARD of the previous OBRA Quarterly Review Assessment or ARD of previous comprehensive assessment, or significant Correction to Prior Quarterly Assessment ( ARD of any of the mentioned assessments + 92 calendar days) and completed timely : the MDS completion date (item Z0500B must be no later than 14days after the ARD (ARD + 14 calendar

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An interview with the Administrator on 10/24/19 at 5:55 pm revealed his expectation was the MDS Assessments should be completed and transmitted in a timely manner per the direction of the RAI manual. He stated the MDS Nurse had been the interim Director of Nursing for 6 to 8 weeks in June and July 2019 and had not been able to keep up with the Minimum Data Sets. The Administrator also stated he had received an email from the corporate office that indicated the facility should not complete or transmit MDS Assessments with and ARD of 10/1/19 or later until notified differently.

b. Resident #23 was admitted to the facility on 3/15/2017 with diagnoses to include diabetes, anxiety and cerebral vascular accident. The most recent quarterly Minimum Data Set assessment dated 7/4/2019 assessed Resident #23 to be cognitively intact without behaviors.

The quarterly assessment dated 10/4/2019 was "in progress" and not completed.

An interview was conducted on 10/23/19 at 4:06 pm with the MDS Nurse stated she had taken over the responsibilities of MDS Nurse and Director of Nursing in June and July of 2019. She stated she did not have any assistance in either role and had fallen behind in the MDS Assessments. The MDS Nurse stated there had also been an issue with the MDS software program and the corporate MDS Consultant had instructed her by email to not complete or transmit MDS Assessments until she notified her due to a software problem. The MDS nurse reported the quarterly assessment for Resident #23 should have been completed by 10/18/2019.

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days). This will be done on weekly basis to include the weekend for 12 weeks then monthly for 3 months. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse.

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| F 638 | Continued From page 18<br>An interview with the Administrator on 10/24/19 at 5:55 pm revealed his expectation was the MDS Assessments should be completed and transmitted in a timely manner per the direction of the RAI manual. He stated the MDS Nurse had been the interim Director of Nursing for 6 to 8 weeks in June and July 2019 and had not been able to keep up with the Minimum Data Sets. The Administrator also stated he had received an email from the corporate office that indicated the facility should not complete or transmit MDS Assessments with and ARD of 10/1/19 or later until notified differently.<br><br>c. Resident #2 was admitted to the facility on 4/26/2019 with diagnoses to include anemia, diabetes and dementia. The most recent quarterly Minimum Data Set assessment dated 6/4/2019 assessed Resident #2 to be severely cognitively impaired without behaviors.<br><br>The quarterly assessment dated 9/4/2019 was "in progress" and not completed.<br><br>The MDS Nurse was interviewed 10/23/19 at 4:06 pm and stated she had taken over the responsibilities of MDS Nurse and Director of Nursing in June and July of 2019. She stated she did not have any assistance in either role and had fallen behind in the MDS Assessments. The MDS Nurse stated there had also been an issue with the MDS software program and the corporate MDS Consultant had instructed her by email to not complete or transmit MDS Assessments until she notified her due to a software problem. The MDS nurse reported the quarterly assessment dated 9/4/2019 for Resident #2 should have been completed by 9/18/2019. | F 638 | | |

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An interview with the Administrator on 10/24/19 at 5:55 pm revealed his expectation was the MDS Assessments should be completed and transmitted in a timely manner per the direction of the RAI manual. He stated the MDS Nurse had been the interim Director of Nursing for 6 to 8 weeks in June and July 2019 and had not been able to keep up with the Minimum Data Sets. The Administrator also stated he had received an email from the corporate office that indicated the facility should not complete or transmit MDS Assessments with and ARD of 10/1/19 or later until notified differently.

d. Resident #10 was admitted to the facility on 12/5/2017 with diagnoses to include heart failure, hypertension and diabetes. The most recent quarterly MDS dated 6/15/2019 assessed Resident #10 to be cognitively intact without behaviors.
The quarterly MDS assessment dated 9/15/2019 was "in progress" and not completed.

The MDS Nurse was interviewed 10/23/19 at 4:06 pm and stated she had taken over the responsibilities of MDS Nurse and Director of Nursing in June and July of 2019. She stated she did not have any assistance in either role and had fallen behind in the MDS Assessments. The MDS Nurse stated there had also been an issue with the MDS software program and the corporate MDS Consultant had instructed her by email to not complete or transmit MDS Assessments until she notified her due to a software problem. The MDS nurse reported the quarterly assessment dated 9/4/2019 for Resident #2 should have been completed by 9/18/2019.The MDS nurse reported the quarterly assessment for Resident #10 should have been

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| F 638 | Continued From page 20<br>completed by 9/29/2019.<br><br>e. Resident #16 was admitted to the facility on 7/2/2016 with diagnoses to include hypertension and dementia. The quarterly MDS dated 6/16/2019 assessed her to be cognitively intact without behaviors.<br><br>The quarterly MDS dated 9/19/2019 was not completed.<br><br>During an interview on 10/23/19 at 4:06 pm the MDS Nurse stated she had taken over the responsibilities of MDS Nurse and Director of Nursing in June and July of 2019. She stated she did not have any assistance in either role and had fallen behind in the MDS Assessments. The MDS Nurse stated there had also been an issue with the MDS software program and the corporate MDS Consultant had instructed her by email to not complete or transmit MDS Assessments until she notified her due to a software problem. The MDS nurse reported the quarterly MDS for Resident #16 should have been completed by 9/30/2019.<br>An interview with the Administrator on 10/24/19 at 5:55 pm revealed his expectation was the MDS Assessments should be completed and transmitted in a timely manner per the direction of the RAI manual. He stated the MDS Nurse had been the interim Director of Nursing for 6 to 8 weeks in June and July 2019 and had not been able to keep up with the Minimum Data Sets.<br>The Administrator also stated he had received an email from the corporate office that indicated the facility should not complete or transmit MDS Assessments with and ARD of 10/1/19 or later until notified differently. | F 638 | | |

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f. Resident #67 was admitted to the facility on 4/22/2019 with diagnoses to include atrial fibrillation, heart failure and hypertension. The most recent quarterly MDS dated 8/28/2019 assessed her to be cognitively intact without behaviors.
The quarterly MDS dated 8/28/2019 was completed on 9/16/2019.
During an interview on 10/23/19 at 4:06 pm the MDS Nurse stated she had taken over the responsibilities of MDS Nurse and Director of Nursing in June and July of 2019. She stated she did not have any assistance in either role and had fallen behind in the MDS Assessments. The MDS Nurse stated there had also been an issue with the MDS software program and the corporate MDS Consultant had instructed her by email to not complete or transmit MDS Assessments until she notified her due to a software problem. The MDS nurse reported the quarterly MDS dated 8/28/2019 should have been completed 9/11/2019.

An interview with the Administrator on 10/24/19 at 5:55 pm revealed his expectation was the MDS Assessments should be completed and transmitted in a timely manner per the direction of the RAI manual. He stated the MDS Nurse had been the interim Director of Nursing for 6 to 8 weeks in June and July 2019 and had not been able to keep up with the Minimum Data Sets. The Administrator also stated he had received an email from the corporate office that indicated the facility should not complete or transmit MDS Assessments with and ARD of 10/1/19 or later until notified differently.

3. A. Resident # 16 was readmitted to the facility

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| F 638 | Continued From page 22<br>on 01/16/2019 with diagnoses that included stage 4 chronic kidney disease, dementia, hypothyroidism, delusional disorder and depression.<br><br>On 10/24/2019 a review of the medical record for Resident # 16 revealed a quarterly MDS with an ARD of 09/16/2019. The assessment (MDS) had not been completed within 14 days plus the ARD date as required by the RAI (Resident Assessment Instruction) manual. The MDS was required to be completed on 09/30/2019.<br><br>An interview with the MDS nurse on 10/23/2019 at 4:06 PM revealed she had taken over the responsibility of Director of Nursing position and continued as the MDS nurse in June and July of 2019. She stated she did not have any assistance with the MDS assessments during this time and had fallen behind. The MDS nurse revealed she had not completed or transmitted Resident # 16's quarterly MDS with an ARD of 09/16/2019. The MDS nurse stated there had also been an issue with the MDS software program and the corporate MDS Consultant had instructed her by email to not complete or transmit MDS Assessments until she notified her due to a software problem.<br><br>An interview with the Administrator on 10/24/2019 at 5:55 PM revealed his expectation was that MDS assessments should be completed and transmitted in a timely manner per the direction of the RAI manual. He stated the MDS Nurse had been the interim Director of Nursing for 6 to 8 weeks in June and July 2019 and had not been able to keep up with the Minimum Data Sets. The Administrator also stated he had received an email from the corporate office that indicated the | F 638 | | |

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facility should not complete or transmit MDS Assessments with and ARD of 10/01/2019 or later until notified differently.

B. Resident # 18 was admitted to the facility on 04/14/2017 with diagnoses that included Alzheimer's dementia, anxiety, anorexia and depression.

A medical record review conducted on 10/22/1019 revealed that a quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) set on 09/20/2019 had been initiated for Resident # 18. The quarterly MDS had not been completed within 14 days plus the ARD date as of 10/22/2019 as required by the RAI (Resident Assessment Instruction) manual. The MDS was required to be completed on 10/04/2019.

An interview with the MDS nurse on 10/23/2019 at 4:06 PM revealed she had taken over the responsibility of Director of Nursing position and continued as the MDS nurse in June and July of 2019. She stated she did not have any assistance with the MDS assessments during this time and had fallen behind. The MDS nurse revealed she had not completed or transmitted Resident # 18's quarterly MDS with an ARD of 09/20/2019. The MDS nurse stated there had also been an issue with the MDS software program and the corporate MDS Consultant had instructed her by email to not complete or transmit MDS Assessments until she notified her due to a software problem.

An interview with the Administrator on 10/24/2019 at 5:55 PM revealed his expectation was that MDS assessments should be completed and

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transmitted in a timely manner per the direction of the RAI manual. He stated the MDS Nurse had been the interim Director of Nursing for 6 to 8 weeks in June and July 2019 and had not been able to keep up with the Minimum Data Sets. The Administrator also stated he had received an email from the corporate office that indicated the facility should not complete or transmit MDS Assessments with and ARD of 10/01/2019 or later until notified differently.

C. Resident # 56 was readmitted to the facility on 05/13/2019 with diagnoses that included end stage renal disease (ESRD), venous thrombosis, convulsions, dementia, dysphagia, muscle weakness and depression.

On 10/22/2019 a review of the medical record for Resident # 56 revealed that a quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) set on 08/16/2019 was completed on 09/09/2019 and the assessment was accepted to the Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) System on 09/10/2019.

A review of the Final Validation Report for the facility dated 09/10/2019 included a warning: the assessment completed late. More than 14 days after the ARD date.

An interview with the MDS nurse on 10/23/19 at 4:06 PM revealed she had taken over the responsibility of Director of Nursing position and continued as the MDS Nurse in June and July of 2019. She stated she did not have any assistance with the MDS assessments during this time and had fallen behind. The MDS nurse revealed that she had not completed or

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transmitted Resident # 56's quarterly MDS with an ARD of 08/16/2019 until 09/09/2019 and transmitted the assessment on 09/10/2019. She stated there had also been an issue with the MDS software program and the corporate MDS Consultant had instructed her by email to not complete or transmit MDS Assessments until she notified her due to a software problem.

An interview with the Administrator on 10/24/2019 at 5:55 PM revealed his expectation was that MDS assessments should be completed and transmitted in a timely manner per the direction of the RAI manual. He stated the MDS Nurse had been the interim Director of Nursing for 6 to 8 weeks in June and July 2019 and had not been able to keep up with the Minimum Data Sets. The Administrator also stated he had received an email from the corporate office that indicated the facility should not complete or transmit MDS Assessments with and ARD of 10/01/2019 or later until notified differently.

D. Resident #3 was admitted to the facility on 05/26/2016 with diagnoses that included: gastro esophageal reflux disease (GERD), hypertension (HTN), intervertebral disc disorder with radiculopathy, dementia, Alzheimer's Disease and sleep apnea.

On 10/24/2019 a review of the medical record for Resident # 3 revealed that a quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) set on 09/02/2019 was completed on 10/23/2019 and the assessment was accepted to the Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) System on 10/24/2019 (QIES ASAP).

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A review of the Final Validation Report for the facility dated 10/24/2019 included a warning: the assessment completed late. More than 14 days after the ARD date.

An interview with the MDS nurse on 10/23/2019 at 4:06 PM revealed she had taken over the responsibility of Director of Nursing position and continued as the MDS Nurse in June and July of 2019. She stated she did not have any assistance with the MDS assessments during this time and had fallen behind. The MDS nurse and had not completed or transmitted Resident # 3's quarterly MDS with an ARD of 09/02/2019 until 10/24/2019. She stated there had also been an issue with the MDS software program and the corporate MDS Consultant had instructed her by email to not complete or transmit MDS Assessments until she notified her due to a software problem.

An interview with the Administrator on 10/24/2019 at 5:55 PM revealed his expectation was that MDS assessments should be completed and transmitted in a timely manner per the direction of the RAI manual. He stated the MDS Nurse had been the interim Director of Nursing for 6 to 8 weeks in June and July 2019 and had not been able to keep up with the Minimum Data Sets. The Administrator also stated he had received an email from the corporate office that indicated the facility should not complete or transmit MDS Assessments with and ARD of 10/01/2019 or later until notified differently.

E. Resident # 19 was admitted to the facility on 03/31/2016 with diagnoses that included cerebral palsy, seizures and hypertension (HTN).

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On 10/24/2019 a review of the medical record for Resident #19 revealed that a quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) set on 09/05/2019 was completed on 10/23/2019 and the assessment was accepted to the Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) System on 10/24/2019 (QIES ASAP).

A review of the Final Validation Report for the facility dated 10/24/2019 included a warning: the assessment completed late. More than 14 days after the ARD date.

An interview with the MDS nurse on 10/23/2019 at 4:06 PM revealed she had taken over the responsibility of Director of Nursing position and continued as the MDS Nurse in June and July of 2019. She stated she did not have any assistance with the MDS assessments during this time and had fallen behind. The MDS nurse revealed that she had not completed or transmitted Resident # 19's quarterly MDS with an ARD of 09/05/2019 until 10/23/2019 and transmitted the assessment on 10/24/2019. She stated there had also been an issue with the MDS software program and the corporate MDS Consultant had instructed her by email to not complete or transmit MDS Assessments until she notified her due to a software problem.

An interview with the Administrator on 10/24/2019 at 5:55 PM revealed his expectation was that MDS assessments should be completed and transmitted in a timely manner per the direction of the RAI manual. He stated the MDS Nurse had been the interim Director of Nursing for 6 to 8 weeks in June and July 2019 and had not been able to keep up with the Minimum Data Sets.

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| F 638 | Continued From page 28<br>The Administrator also stated he had received an email from the corporate office that indicated the facility should not complete or transmit MDS Assessments with and ARD of 10/01/2019 or later until notified differently. | F 638 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews, the facility failed to maintain a safe environment by storing two opened chemical disinfectant spray cans in an unlocked location in 1 of 3 shower rooms observed (400 hall).<br><br>Findings included:<br><br>The shower room on the 400 hall was observed on 10/21/2019 at 11:07 AM. The shower room door was unlocked and there was no visible lock on the inside or outside of the door. On the wall on the right side of the shower room the sink was mounted to the wall and an uncovered spray can labeled Disinfectant Deodorant was observed on the outer rim of the sink. Another spray can labeled Disinfectant Deodorant spray was observed on the inside top shelf of a gray and black plastic storage unit located on the wall to the left of the inside of the shower room. The | F 689 | On 10/24/2019 the chemical disinfectant spray was given to the Maintenance Director and secured on the housekeeping cart. The Director of Nursing removed extra supplies that had been stored in the shower rooms and the Maintenance Director removed and discarded unlocked black cabinets from all shower rooms on the evening of 10/24/19.<br><br>On 10/24/2019 Director of Nursing and Maintenance completed 100% audit of all other shower rooms and building sweep for any other unsecured chemicals with no other issues noted.<br><br>On 11/12/2019 Staff development nurse and Maintenance Director began in-services for all facility staff on safety | 11/19/19 |

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| F 689 | Continued From page 29<br>doors of the cabinet were observed ajar and there was visible lock for the doors. The Disinfectant Deodorant cans were labeled with listed ingredients of ethyl alcohol, ortho-benzyl- para -chlorophenol and ortho-phenyl phenol. A warning on the cans included "to keep out of reach of children." Other warnings listed included may cause eye irritation, may cause skin irritation, may be harmful if swallowed and the inhalation of vapors may cause respiratory irritation.<br><br>On 10/22/2019 at 7:48 AM an observation of the 400-hall shower room was conducted and revealed the 2 spray cans labeled Disinfectant deodorant remained in the same locations that they were observed on 10/21/2019.<br><br>An observation of the 400-hall shower room was conducted on 10/23/2019 at 1:36 PM. The gray and black plastic storage unit was pushed against the interior left wall with the 2 doors on the cabinet pushed against the wall. The storage unit was easily moved away from the wall and its 2 doors swung open and exposed 2 opened cans of spray Disinfectant Deodorant. There was no can located on the sink rim in the shower room.<br><br>On 10/24/2019 at 7:26 AM an observation of the 400-hall shower room revealed that plastic shelf unit pushed back against the left wall with the doors against the wall. When the unit was pushed away from the wall the doors opened and revealed the 2 spray cans of opened Disinfectant Deodorant remained in the same place on the cabinet.<br><br>An interview conducted with nurse assistant (NA) # 2 on 10/24/2019 at 9:47 AM revealed that the NA was not aware of the cans of Disinfectant | F 689 | practices and securing chemicals. This will be completed on 11-15-2019.<br><br>On 11/20/2019 The Director of Nursing will begin daily audits of all three shower rooms for two weeks. The Manager on Duty will complete daily audits of all three showers rooms on the weekends for two weeks. These audits will reflect weekend and off shifts. Weekly observation/ audits of 3 shower rooms will then be completed using a quality assurance (QA) survey tool for 4 weeks then monthly for 3 months. Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Social Services Director, MDS Coordinator, Unit Manager, Support nurse, Maintenance /Environmental Services director , Therapy director , Health information manager, Dietary Manager. | |

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| F 689 | Continued From page 30<br>Deodorant spray in the shower room and the NA was not able to explain how the spray cans got in the shower room. NA # 2 revealed that she thought that only housekeeping staff used that spray.<br><br>Housekeeper # 1 was interviewed on 10/24/2019 at 11:27 AM. The housekeeper revealed that she cleaned the shower room on the 400 hall and that she did use the spray disinfectant deodorant at times in the shower room but not if any residents or staff were in the room. Housekeeper revealed that she did not leave the cans in the shower room or any other rooms and that she had one can in her possession and when not in use it was maintained locked securely in her cart.<br><br>A tour of the shower room on the 400 hall was conducted with the environmental service director (ESD) on 10/24/2019 at 11:35 AM. The ESD revealed that the housekeepers did not leave any cleaning chemicals in the shower rooms and that all chemicals that were used were maintained in each locked housekeeper cart. The ESD stated that the shower room doors were never locked and were not equipped to be locked. The ESD observed the gray and black plastic storage unit with the doors pushed against the left wall in the shower room and the ESD observed the surveyor pull the plastic shelf away from the wall and the 2 doors opening and exposing 2 open cans of Disinfectant Deodorant spray inside the cabinet. The ESD removed the cans from the storage unit and revealed that the cans should not be left in the shower room and that he was certain that the housekeeper did not leave the cans in the room and that he had no idea which staff brought the spray cans into the shower room and left them there. The ESD removed the 2 cans immediately. | F 689 | | |

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| F 689 | Continued From page 31<br>The ESD revealed that he would research the possibility of placing a lock on the storage unit to keep the doors closed and secured.<br><br>During a tour of the 400 hall shower room with the Director of Nurses (DON) on 10/24/2019 at 12:12PM, the DON revealed that she did not know that 2 cans of Disinfectant Deodorant spray had been observed in the 400 hall shower room and was not aware that there was not a securely locked cabinet in the shower room to store any items. The DON stated that she believed the nurse staff brought the cans into the shower room and that she would provide staff education about use and storage of chemicals to the nurse staff and would discuss the need for a secured or locked storage cabinet in all the shower rooms with the facility administrator and ESD.<br><br>On 10/24/2019 at 5:40 PM the facility admin was interviewed and revealed that the housekeeping staff and nurse staff were expected to not leave any harmful chemicals unlocked in the shower rooms or anywhere else in the facility. | F 689 | | |
| F 693 SS=D | Tube Feeding Mgmt/Restore Eating Skills<br>CFR(s): 483.25(g)(4)(5)<br><br>§483.25(g)(4)-(5) Enteral Nutrition<br>(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-<br><br>§483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical | F 693 | | 11/19/19 |

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| F 693 | Continued From page 32<br>condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and<br><br>§483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews, the facility failed to discard bottles of tube feeding formula with expired expiration dates that were stored in 1 of 2 medication rooms observed (100-200-300 hall medication room).<br><br>Findings included:<br><br>The medication room for the facility ' s 100, 200, 300 halls was observed on 10/24/2019 at 5:06 PM. During this observation seven 8-ounce bottles of tube feeding formula were observed on the shelf with an expiration date of 10/1/2019. The Unit Manager was interviewed at the time of the observation and she reported the expired bottles of tube feeding formula should have been discarded.<br><br>The Director of Nursing (DON) was interviewed on 10/24/2019 at 5:10 PM and she reported she had checked the expiration dates of all the nutritional supplements and the tube feeding formulas that morning, but she misread the expiration date on the tube feeding formula. The DON reported the transporter aide will put the stock into the medication room, but the nursing | F 693 | On 10/24/2019 the Director of Nursing removed cartons of tube feeding with October 2019 dates from medication room and were discarded. No residents residing in the facility receive tube feedings.<br><br>On 10/24/2019 the Director of Nursing checked 100% other medication rooms and tube feeding cartons for expired dates. Those findings were that there were no other expired tube feeding cartons<br><br>On 11-12-2019 the Staff Development Nurse and Director Of Nursing began in-services for Tube Feeding management including tube feeding storage for observation of dates listed on containers for all facility licensed nursing staff This will be completed by 11-15-2019.<br><br>On 11-20-2019 The Director of Nursing will begin weekly observation/ audits of 2 medication rooms using a quality | |

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| F 693 | Continued From page 33<br>staff unpack the stock and check expiration dates, and she or the Unit Manager will double check the expiration dates, but she did not have a schedule for performing this task. The DON reported it was her expectation that expired nutritional supplements or tube feeding formulas were discarded by their expiration date. | F 693 | assurance (QA) survey tool.<br>Observations /audits reports will be completed for 4 weeks then monthly for 3 months. Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Social Services Director, MDS Coordinator, Unit Manager, Support nurse, Maintenance /Environmental services director, Therapy director, Health information manager, Dietary Manager.<br>The Director of Nursing is responsible for the Plan of Correction | |
| F 695<br>SS=D | Respiratory/Tracheostomy Care and Suctioning<br>CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.<br>The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, resident, staff and nurse practitioner interviews, the facility failed to obtain a physician order for Oxygen (O2) therapy for 1 of 2 resident reviewed for oxygen therapy (Resident #11) and failed to change oxygen tubing and oxygen concentrator filters for 1 of 2 residents reviewed for oxygen therapy (Resident #74). | F 695 | On 10/24/2019 the Unit manager changed resident # 74 oxygen tubing. On 10/24/2019 the Director of Nursing cleaned resident #74 concentrator filter.<br>On 10/24/2019 resident #11 a had signed standing orders for PRN oxygen use concentrator was removed by Unit manager and was not needed. | 11/19/19 |

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Findings included:

1. Resident #11 was admitted to the 12/7/2018 with diagnoses to include hypertension, glaucoma and collapsed vertebra.

The physician orders were reviewed, and an order dated 5/13/2019 read "O2 at 2 liters per minute (lpm) titrate to keep (oxygen) saturation levels greater than 93%, one time only for hypoxia (low oxygen level) for one day."

The most recent quarterly Minimum Data Set (MDS) assessment dated 6/16/19 assessed Resident #11 to be cognitively intact without behaviors and that she used oxygen.

Resident #11 ' s care plans which were initiated on 12/7/2018 were reviewed and no care plans were in place to address the use of oxygen.

Current standing orders for Resident #11 were reviewed. There was an order to apply O2 if oxygen saturation levels were less than 89% on room air.

Resident #11 was observed on 10/21/2019 at 10:16 AM with O2 on at 2 lpm by nasal cannula. Resident #11 reported she used O2 to help with her breathing. Resident #11 reported she wore the O2 "all the time".

Nurse #1 was interviewed on 10/23/2019 at 9:32 AM and she reported that Resident #11 became short of breath at time and she had O2 ordered to help with her oxygen levels and she thought Resident #11 wore the O2 continuously. Nurse #1 reported she thought Resident #11 had a

F 695

On 10/28/2019 100% audit was completed by float Registered nurse of resident utilizing oxygen for orders, for dates of oxygen tubing changes and cleanliness of the concentrator filter. Nine residents who had oxygen orders were audited and of those nine, all filters were clean and tubing was found dated and in compliance. Those findings were that all resident utilizing oxygen had orders, and standing orders PRN, filters were clean and tubing was dated.

On 11-12-2019 the Director of Nursing and Staff Development nurse education on oxygen utilization, tubing change, and concentrator filter maintenance.

On 11-20/2019 The Director of Nursing will begin weekly observation/ audits of 5 residents utilizing oxygen, tubing and concentrator maintenance using a quality assurance (QA) survey tool. The Director of Nursing will monitor this for eight weeks. Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Social Services Director, MDS Coordinator, Unit Manager, LPN support nurse, Maintenance /Environmental services director, Therapy director, Health information manager, Dietary Manager.

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physician order for oxygen, but she wasn ' t certain.

Resident #11 was interviewed on 10/23/2019 at 9:40 AM and she reported that the staff checked her oxygen level and said she was "okay", and the oxygen was taken off on 10/22/2019. Resident #11 reported she was not having difficulty breathing.

Nursing assistant #5 was interviewed 10/23/2019 at 1:45 PM and she reported she observed Resident #11 wearing the O2 "most of the time."

The Unit Manager was interviewed on 10/24/2019 at 9:59 AM and she reported the facility used standing orders for oxygen use and the staff would not need further orders.

The nurse practitioner (NP) for the facility was interviewed on 10/24/2019 at 12:02 PM and she reported if a resident was using O2, she would expect to see communication between the nurse and the NP or physician and order for the oxygen use. The NP explained the standing orders were used to start O2 for a resident who was hypoxic (low oxygen level) but clarifying and monitoring orders should be obtained for continued use of O2 for a resident. The NP was not aware Resident #11 was using oxygen.

The Director of Nursing (DON) was interviewed on 10/24/2019 at 3:53 PM and she reported the facility standing orders would cover the nurse to initiate O2 therapy for a resident, however, the nursing staff should have communicated Resident #11 ' s continued O2 use to the physician or NP to receive additional orders and they should have initiated a care plan to address

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the use of oxygen. The DON reported she expected nursing staff to receive clarification for standing orders and to see documentation of the communication with the physician.

2. Resident #74 was admitted to the facility 2/17/2017 and her most recent readmission was dated 9/5/2019. Diagnoses for Resident #74 included chronic obstructive pulmonary disease, emphysema and diabetes. The admission Minimum Data Set assessment (MDS) dated 9/12/2019 assessed Resident #74 to be cognitively intact without behaviors. The MDS assessed Resident #74 to use Oxygen (O2)

a. A review of the physician orders for Resident #74 revealed an order dated 9/5/2019 for O2 at 4 liters per minute by nasal cannula continuously and to change the O2 tubing weekly (Wednesday).

The medication administration record (MAR) for Sept 2019 was reviewed and the task "change O2 tubing every week night shift: Wednesday" was noted on the MAR with nurse initials on 9/11/19 (Nurse #5), 9/18/19 (Nurse #4) and 9/25/19 (Nurse #5) which indicated the task had been completed.

The MAR for October 2019 was reviewed and the task "change O2 tubing every week night shift: Wednesday" was noted and nurses initials were noted on 10/2/19 (Nurse #4), 10/9/19 (Nurse #4), 10/19/19 (Nurse #5) and 10/23/19 (Nurse #5) which indicated the task had been completed.

Resident #74 was observed on 10/21/2019 at 12:35 PM and she was wearing O2 at 4lpm with nasal cannula. The O2 tubing was dated

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9/25/2019.

An observation of Resident #74 was conducted on 10/22/2019 at 11:31 AM. The O2 tubing was dated 9/25/2019.

The O2 tubing was observed on 10/23/2019 at 9:36 AM and the tubing was dated "10/22/2019".

An interview was conducted with Resident #74 on 10/22/2019 at 11:31 AM and she reported she was not certain when the O2 tubing had been changed.

Resident #74 was interviewed on 10/23/2019 at 9:36 AM and she reported her O2 tubing had been changed during the night on 10/22/2019.

Nurse #1 was interviewed on 10/23/2019 at 9:40 AM and she reported the O2 tubing was to be changed on night shift, and she was not aware of the date on the O2 tubing for Resident #74.

A phone interview was conducted with Nurse #4 on 10/23/2019 at 5:21 AM and she reported she frequently provided care for Resident #74 on night shift. Nurse #4 reported changing the O2 tubing was a responsibility for night shift nurses and the task was completed on Wednesday nights. Nurse #4 explained that she changed the O2 tubing for Resident #74 several times over the past month but was not certain of the specific dates. Nurse #4 reported Resident #74 had extension tubing and wondered if the O2 cannula portion had been changed and not the entire tubing set. Nurse #4 reported she was not aware the tubing for Resident #74 was dated 9/25/2019.

A phone interview was conducted with Nurse #5

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on 10/24/2019 at 5:41 AM and she reported she had provided care for Resident #74 frequently over the past month on night shift. Nurse #5 reported Resident #74 had extension tubing on the O2 tubing and all the tubing should have been changed weekly, but she was not certain if she had changed the tubing for Resident #74. Nurse #5 reported she was not aware the tubing on Resident #74 was dated 9/25/219.

The Unit Manager was interviewed on 10/24/2019 at 9:59 AM and she reported that the nasal cannula plus the extension tubing should be changed weekly and she was not aware the O2 tubing for Resident #74 was dated 9/25/2019.

The Director of Nursing (DON) was interviewed on 10/24/2019 at 3:53 PM and she reported that the O2 tubing should be changed, including the nasal cannula and the extension tubing weekly and as needed if soiled, and she reported that she would need to start checking behind the nurses to make certain a task was completed when it was initialed on the MAR.

The Administrator was interviewed on 10/24/2019 at 5:36 PM and he reported he expected the nurses to change the O2 tubing as the physician ordered.

b. A physician order dated 9/8/2019 instructed the filter to the O2 concentrator was to be cleaned weekly (Wednesday).

The MAR for Sept 2019 was reviewed and the task "clean O2 concentrator filter every week day shift: Wednesday" was noted on the MAR with nurse initials on 9/11/19, 9/18/19 and 9/25/19 which indicated the task had been completed.

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The MAR for October 2019 was reviewed and the task "change O2 concentrator filter every week day shift: Wednesday" was noted and nurses initials were noted on 10/2/19, 10/9/19, 10/19/19 and 10/23/19 which indicated the task had been completed.

Resident #74 was observed on 10/21/2019 at 12:35 PM and the filters on the O2 concentrator were noted to have a dry, fluffy white substance imbedded in the filters and when touched, became airborne.

Resident #74 was observed on 10/21/2019 at 12:35 PM and the O2 concentrator filters had a dry, fluffy white substance imbedded in them and became airborne when touched.

An observation of Resident #74 was conducted on 10/22/2019 at 11:31 AM and the filters continued to have a dry, fluffy white substance imbedded in them and when touched, the substance became airborne.

Resident #74 was interviewed on 10/23/2019 at 9:36 AM and she stated she was not certain when the filters on her O2 concentrator had been cleaned.

An interview was conducted with Nurse #1 on 10/23/2019 at 9:40 AM and she reported she was not certain when the O2 concentrator filters were supposed to be cleaned, but she thought it was a responsibility of night shift. Nurse #1 observed the O2 concentrator filters for Resident #74 and reported the filters looked very dusty and she removed them to be cleaned.

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| F 695 | Continued From page 40<br>A phone interview was conducted with Nurse #4 on 10/24/2019 at 5:21 AM and she reported the O2 concentrator filters were cleaned weekly, on Friday night.<br><br>Nurse #5 was interviewed by phone call on 10/24/2019 at 5:41 AM and she reported the O2 concentrator filters were supposed to be cleaned on Friday, night shift.<br><br>The Unit Manager was interviewed on 10/24/2019 at 9:59 AM and she reported she had observed dirty and dusty O2 concentrator filters in the past and she was not certain why Resident #74 ' s filters were not cleaned.<br><br>The Director of Nursing (DON) was interviewed on 10/24/2019 at 3:53 PM and she reported that the O2 tubing should be changed, including the nasal cannula and the extension tubing weekly and as needed if soiled, and she reported that she would need to start checking behind the nurses to make certain a task was completed when it was initialed on the MAR.<br><br>The Administrator was interviewed on 10/24/2019 at 5:36 PM and he reported he expected the nurses to clean the O2 concentrator filters as the physician ordered. | F 695 | | |
| F 812<br>SS=F | Food Procurement,Store/Prepare/Serve-Sanitary<br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. | F 812 | | 11/19/19 |

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| F 812 | Continued From page 41<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(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.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews the facility failed to ensure foods were covered and labeled when stored in 1 of 2 kitchen observations.<br><br>On 10/21/19 at 10:03 am an initial observation of the kitchen revealed there were three metal containers of food that had been covered in clear wrap and labeled but the edge of the clear wrap had been pulled back on each container and left open. The first container dated 10/22/19 was ground meat; the second container was puree eggs and was dated 10/21/19; and the third container was dated 10/23/19 and contained gravy. A large metal pan of liquid eggs was not labeled with the date. The Dietary Manager was present during the initial observation and stated the three pans labeled and dated with future dates had been dated for the dates they were to be used and should have been dated for the date they were stored.<br><br>During an interview on 10/24/19 at 9:21 am with the Dietary Manager she stated the kitchen staff | F 812 | The items that did not have a label and date were removed and the dietary staff member who failed to properly store and date items found during survey inspection was verbally counseled by the dietary manager on proper storage protocol on 10/25/19.<br><br>All residents have the potential to be affected by the alleged deficient practice. On 10/21/19 the Dietary Manager completed a kitchen inspection to ensure all food items were properly stored and dated.<br><br>In-service education was provided to all full time, part time, and as needed staff on 11/13/19 and the topics included all food items must be stored per NC State Regulations and Food Safety, Date Marking Policy reviewed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff | |

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| F 812 | Continued From page 42<br>usually cover food to be stored in the walk-cooler with plastic wrap and date it with the day it is covered and placed in the cooler. The Dietary Manager stated they must have failed to wrap the plastic wrap around the edges of the pans that were observed on 10/21/19. She further stated the large metal pan of liquid eggs with no label or date was placed in the cooler by the cook who must have forgotten to label the pan.<br><br>An interview with the Dietician revealed she thought it was acceptable for the film wrap to be left open while food was cooling to allow staff to check the temperature. She also stated the cook had failed to label and date the pan of liquid eggs that morning.<br><br>The Administrator was interviewed on 10/24/19 at 2:51 pm and stated he was concerned with issues found in the kitchen and expected the kitchen staff to store food properly to protect the facilities residents. | F 812 | and will be reviewed by the Quality Assurance process to verify that the change has been sustained.<br><br>The Dietary Manager will monitor food storage weekly x 2 weeks then monthly x 3 months using the Dietary QA Audit Tool. Monitoring will include auditing all areas of the kitchen in which food is stored. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager | |
| F 865<br>SS=F | QAPI Prgm/Plan, Disclosure/Good Faith Attmpt<br>CFR(s): 483.75(a)(2)(h)(i)<br><br>§483.75(a) Quality assurance and performance improvement (QAPI) program.<br><br>§483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation;<br><br>§483.75(h) Disclosure of information.<br>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. | F 865 | | 11/19/19 |

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| F 865 | Continued From page 43<br><br>§483.75(i) Sanctions.<br>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews 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 December 2018. This was for 2 re-cited deficiencies which were originally cited on 11/30/2018 (F636 and F638) during the recertification/complaint survey and on the current recertification survey on 10/24/2019 (F636 and 638). 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:<br>This tag is cross referred to:<br><br>1. F636 Based on record review and staff interviews the facility failed to complete a comprehensive assessment for 9 of 9 residents reviewed for completion of a comprehensive assessment within 366 days of the previous comprehensive assessment and within 14 days after admission to the facility (Resident #8, #4, #230, #80, #5, #129, #179, #38, and #36).<br><br>An interview was conducted with the Administrator on 10/24/2019 at 6:11 PM and he reported the QAPI committee met once per month with participation of all the department heads, including the MDS (Minimum Data Set) nurse the facility physician and the pharmacist. | F 865 | This tag is cross reference to F636 Comprehensive Assessment Timing and F638 Quarterly Assessment at least every 3 months.<br><br>F636 Comprehensive Assessment Timing:<br>Resident #8. Annual Comprehensive Assessment, Assessment Reference Date (ARD) 9/9/2019. Completed, Submitted and Accepted on 10/29/2019 to the State Quality Improvement Evaluation System QIES system<br>Resident #4. Annual Comprehensive Assessment, Assessment Reference Date (ARD) 9/4/2019. Completed, Submitted and Accepted on 10/24/2019 to the State QIES system<br>Resident #230. Admission Comprehensive Assessment, Assessment Reference Date (ARD) 10/7/2019. Completed, Submitted and Accepted on 10/22/2019 to the State QIES system<br>Resident #80. Admission Comprehensive Assessment, Assessment Reference Date (ARD) 7/1/2019. Completed, Submitted and Accepted on 8/13/2019 to the State QIES system<br>Resident #5. Annual Comprehensive Assessment, Assessment Reference Date (ARD) 09/05/2019. Completed, Submitted and Accepted on 10/24/2019 to | |

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F 865

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The Administrator explained he had not been aware there were issues with the MDS process and completing assessments and the MDS nurse should have let the QAPI committee know that she was behind on the assessments. The Administrator reported the QAPI was only as good as the information the committee had and if they were not aware of the issue, they could not address the MDS issues. The Administration reported he expected the assessments were completed appropriately.

2. F638 Based on record review and staff interviews the facility failed to complete and submit a Quarterly Minimum Data Set (MDS) Assessment within 14 days of the Assessment Reference Date (ARD) and every 92 days to the Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) System (QIES ASAP) for 16 of 17 Residents #7, #9, #12, #50, #79, #11, #23, #2, #10, #16, #67, #16, #18, #56, #3, #19.
An interview was conducted with the Administrator on 10/24/2019 at 6:11 PM and he reported the QAPI committee met once per month with participation of all the department heads, including the MDS nurse the facility physician and the pharmacist. The Administrator explained he had not been aware there were issues with the MDS process and completing assessments and the MDS nurse should have let the QAPI committee know that she was behind on the assessments. The Administrator reported the QAPI was only as good as the information the committee had and if they were not aware of the issue, they could not address the MDS issues. The Administration reported he expected the assessments were submitted appropriately.

F 865

the State QIES system
Resident #129. Admission Comprehensive Assessment, Assessment Reference Date (ARD) 9/12/2019. Completed, Submitted and Accepted on 10/16/2019 to the State QIES system
Resident #179 Significant Change Comprehensive Assessment, Assessment Reference Date (ARD) 10/22/2019. Completed, Submitted and Accepted on 10/22/2019 to the State QIES system
Resident #38. Admission Comprehensive Assessment, Assessment Reference Date (ARD) 7/12/2019. Completed, Submitted and Accepted on 8/7/2019 to the State QIES system
Resident #36. Admission Comprehensive Assessment, Assessment Reference Date (ARD) 7/16/2019. Completed, Submitted and Accepted on 8/12/2019 to the State QIES system
F638 Quarterly Assessment at least every 3 months
Resident #7 Quarterly Assessment Reference Date (ARD) 9/9/2019. Completed, Submitted and Accepted on 10/25/2019 to the State Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) system.
Resident #9 Quarterly Assessment Reference Date (ARD) 9/12/2019. Completed, Submitted and Accepted on 10/28/2019 to the State QIES ASAP system.
Resident #12 Quarterly Assessment Reference Date (ARD) 9/19/2019. Completed, Submitted and Accepted on 10/29/2019 to the State QIES ASAP

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| F 865 | Continued From page 45 | F 865 | system.<br>Resident #50 Quarterly Assessment Reference Date (ARD) 8/11/2019. Completed, Submitted and Accepted on 9/5/2019 to the State QIES ASAP system.<br>Resident #79 Quarterly Assessment Reference Date (ARD) 7/18/2019. Completed, Submitted and Accepted on 8/13/2019 to the State QIES ASAP system. Resident Discharged.<br>Resident #11 Quarterly Assessment Reference Date (ARD) 9/19/2019. Completed, Submitted and Accepted on 10/29/2019 to the State QIES ASAP system.<br>Resident #23 Quarterly Assessment Reference Date (ARD) 10/4/2019. Completed, Submitted and Accepted on 10/30/2019 to the State QIES ASAP system.<br>Resident #2 Quarterly Assessment Reference Date (ARD) 9/4/2019. Completed, Submitted and Accepted on 10/24/2019 to the State QIES ASAP system.<br>Resident #10 Quarterly Assessment Reference Date (ARD) 9/15/2019. Completed, Submitted and Accepted on 10/28/2019 to the State QIES ASAP system.<br>Resident #16 Quarterly Assessment Reference Date (ARD) 9/16/2019. Completed, Submitted and Accepted on 10/29/2019 to the State QIES ASAP system.<br>Resident #67 Quarterly Assessment Reference Date (ARD) 8/28/2019. Completed, Submitted and Accepted on 9/17/2019 to the State QIES ASAP | |

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| F 865 | Continued From page 46 | F 865 | system.<br>Resident #16 Quarterly Assessment Reference Date (ARD) 9/16/2019. Completed, Submitted and Accepted on 10/29/2019 to the State QIES ASAP system.<br>Resident #18 Quarterly Assessment Reference Date (ARD) 9/20/2019. Completed, Submitted and Accepted on 10/29/2019 to the State QIES ASAP system. Resident discharged.<br>Resident #56 Quarterly Assessment Reference Date (ARD) 8/16/2019. Completed, Submitted and Accepted on 9/10/2019 to the State QIES ASAP system.<br>Resident #3 Quarterly Assessment Reference Date (ARD) 9/2/2019. Completed, Submitted and Accepted on 10/24/2019 to the State QIES ASAP system.<br>Resident #19 Quarterly Assessment Reference Date (ARD) 9/5/2019. Completed, Submitted and Accepted on 10/24/2019 to the State QIES ASAP system.<br><br>This tag is cross reference to F636 Comprehensive Assessment Timing and F638 Quarterly Assessment at least every 3 months.<br>All current residents with Comprehensive Minimum Data Set (MDS) assessments due have the potential to be affected by the alleged practice. On 11/11/2019 through 11/14/2019 an audit was completed by the MDS Nurse consultant to ensure that the facility had conducted a comprehensive, accurate, standardized | |

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| F 865 | Continued From page 47 | F 865 | reproducible assessment of each resident□s functional capacity. Out of the 84 current residents, 8 number of residents did not have their comprehensive assessments completed within 14 calendar days after admission, excluding readmission in which there is no significant change in the resident□s physical or mental condition and 4 number of resident did not have their Annual comprehensive assessments completed by timeframes. This assessments were completed by 11/15/2019.<br>All current residents with Quarterly Minimum Data Set (MDS) assessments due have the potential to be affected by the alleged practice. On 11/11/2019 through 11/15/2019 an audit was completed by the MDS Nurse consultant to ensure that the facility had conducted Quarterly Review assessment of each resident□s. Out of the 84 current residents, 0 number of residents did not have their quarterly review assessments completed within 92days since the ARD of the previous OBRA Quarterly Review Assessment or ARD of previous comprehensive assessment. This assessments were completed and submitted by 11/15/2019.<br><br>On 11/12/2019, The Quality Assurance Nurse in serviced the Administrator in reference to the Quality Assessment and Assurance. A facility must maintain a quality assessment and assurance committee consisting at a minimum of:(i) The director of nursing services;(ii) The | |

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| F 865 | Continued From page 48 | F 865 | Medical Director or his/her designee;(iii) At least three other members of the facility□s staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and The quality assessment and assurance committee must :(i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;(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. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.<br><br>Effective 11/12/2019, this training is incorporated into the new employee orientation program. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.<br><br>To ensure compliance, Administrator or Director of Nursing will monitor this issue using a quality assurance (QA) survey tool. Facility will monitor compliance of QA for F638 and F636. This will be done on | |

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| F 865 | Continued From page 49 | F 865 | weekly basis to include the weekend for 4 weeks then monthly for 3 months. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse. | |