STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345523	A. BUILDING ______ B. WING ______	C 10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/RAMSEUR	7166 JORDON ROAD RAMSEUR, NC 27316

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification and Complaint survey was conducted on 10/21/19 through 10/24/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. See Event # 60WF11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted on 10/21/19 through 10/24/19. Two of five complaint allegations were substantiated resulting in deficiencies (F584 & F745).	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response.	F 565		11/21/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 11/15/2019

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 565	Continued From page 1 (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, and interviews with residents and staff, the facility failed to resolve repeat concerns reported during Resident Council meetings for 6 of 6 consecutive months. The findings included: Review of the monthly Resident Council meeting minutes dated 4/29/19 included, in part, concerns related to staff utilizing cell phones when working in the dining room, trash cans not being emptied, and not being given fresh ice throughout the day. These minutes were recorded by the Activities Director. Review of the monthly Resident Council meeting minutes dated 5/29/19 included, in part, the repeat concerns of staff utilizing cell phones when working in the dining room and trash cans not being emptied. The new concern of not having enough linens (clothing protectors) was also discussed at this meeting. These minutes were recorded by the Activities Director. Review of the monthly Resident Council meeting	F 565	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F565 The following will be accomplished for residents having been affected by the practice: The newly reinstituted "Resident Council Concern Form" was completed to include concerns voiced by the Resident Council	

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F 565 Continued From page 2

minutes dated 6/28/19 included, in part, the repeat concern of staff utilizing cell phones when working in the dining room. These minutes were recorded by the Activities Director.

Review of the monthly Resident Council meeting minutes dated 7/30/19 included, in part, the repeat concern of staff utilizing cell phones when working in the dining room. These minutes were recorded by the Activities Director.

Review of the monthly Resident Council meeting minutes dated 8/26/19 included, in part, the repeat concerns of trash cans not being emptied, fresh ice not being given, and not having enough clothing protectors. These minutes were recorded by the Activities Director.

Review of the monthly Resident Council meeting minutes dated 9/30/19 included, in part, the repeat concerns of not having enough clothing protectors, trash cans not being emptied, and fresh ice not being given. These minutes were recorded by the Activities Director.

A Resident Council meeting was conducted on 10/23/19 at 10:00 AM with 4 alert and oriented residents who were active participants in the facility's Resident Council. The residents reported that they had repeat concerns over the past several months that included staff utilizing cell phones when working in the dining room, trash cans not being emptied, fresh ice not being passed, and not having enough clothing protectors for the dinner meal. The meeting attendees all stated that these concerns had not been resolved. When asked what the facility ' s response was to them regarding these repeat concerns the group indicated they had not

F 565

in previous six months and distributed to appropriate disciplines for resolution on 11- 13-19. The resolutions will be presented to the residents by the Administrator at the resident council meeting on November 19,2019.

The following will be accomplished for residents who have the potential to be affected by the practice:

A response form for concerns expressed by the Resident Council has been reinstituted and will be completed at each Resident Council Meeting by the meeting facilitator as applicable. The facilitator will distribute the completed concern forms to the appropriate disciplines for resolution. The facilitator will provide copies to the administrator. On 11/13/19, the Administrator provided education to the Resident Council Facilitator (Activity Director) concerning utilizing the resident council concern form to record any council concerns and the process for follow-up by distributing the completed concern form to the appropriate discipline with copy to the Administrator.

The following system has been put in place to ensure that the practice does not recur:

The Resident Council facilitator (Activity Director) will complete the Resident Council Concern forms at each meeting and forward the forms to the appropriate discipline within twenty-four hours of the meeting. The disciplines will put action

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F 565	Continued From page 3 received any response to these concerns. The residents reported that they got tired of reporting the same concerns month after month with no response so sometimes they just stopped reporting them. An interview was conducted with the Activities Director on 10/23/19 at 12:00 PM. She reported that she had assumed responsibility for holding the Resident Council meetings when the facility ' s previous Social Worker left on 12/31/18. She stated that she had only attended 1 Resident Council meeting in December 2018 prior to taking over this responsibility. The Activities Director confirmed there were multiple repeat issues that came up month after month with no follow up and/or resolution provided to the Resident Council members. She explained that after each meeting she reported the issues verbally to the facility ' s former Administrator and she indicated she would take care of the concerns. The Activities Director stated that at the next meeting the same issues were brought up and she just wrote them down again and then reported them to the former Administrator. She revealed that this happened over and over again and sometimes she felt like she should just copy the previous meetings minutes, so she didn ' t have to rewrite the same things. She stated that she had not known what else to do with the repeat concerns as she was following the instructions given to her by her boss, the former Administrator. An interview was conducted with the Administrator on 10/24/19 at 12:01 PM. She stated that she had just began working as the Interim Administrator at the end of August 2019	F 565	plans in place to resolve the concerns as much as possible within forty-eight hours of receipt. The forms, with the resolutions, will be returned to the administrator and the meeting facilitator to share with the residents at the next meeting. The forms will be attached to the meeting minutes by the meeting facilitator and logged in the Grievance/Concern Log. The following monitoring system will be implemented to ensure that the solution is sustained: The Administrator will review all Resident Council concerns and resolutions monthly. Resident Council concerns will be presented to the Quality Assurance and Improvement Committee to ensure that the concerns are resolved and the corrective action is sustained. The plan will be revised as deemed necessary.	

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F 565	Continued From page 4 and was not aware that the Resident Council members reported repeat concerns month after month. She indicated that her expectation was for all issues/concerns discussed at the Resident Council meetings to be reviewed and/or investigated as needed with follow up being provided to the Resident Council members.	F 565		
F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is	F 582		11/21/19

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F 582	Continued From page 5 reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure a Skill Nursing Facility Advanced Beneficiary Notice (SNF ABN) and/or a Notice of Medicare Non-Coverage (NOMNC) was provided as required to 3 of 3 residents reviewed for Beneficiary Protection Notification (Residents #76, #84, and #85). The findings included: 1. Resident #76 was most recently admitted to the facility on 7/4/19. The admission Minimum Data Set (MDS) assessment dated 7/11/19 indicated his cognition was moderately impaired.	F 582	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.	

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F 582	Continued From page 6 Review of Resident #76 ' s record indicated he had Medicare covered Part A Services from 7/4/19 through 8/20/19 and remained in the facility when the coverage for his Part A Services ended. The record revealed Resident #76 was not provided with a Skill Nursing Facility Advanced Beneficiary Notice (SNF ABN/CMS-10055) or a Notice of Medicare Non-Coverage (NOMNC/CMS-10123) as required when his coverage for Part A services ended (8/20/19). An interview was conducted with the Administrator on 10/22/19 at 3:30 PM. She stated that the former Administrator was responsible for providing the beneficiary notifications to the resident and/or Responsible Party (RP). She revealed they had no record that a SNF ABN or NOMNC was provided to Resident #76. She stated that she expected the regulations regarding beneficiary notifications to be followed and that she was already in the process of completing an action plan to correct the issue. 2. Resident #84 was admitted to the facility on 4/18/19 and most recently readmitted on 7/9/19. The admission Minimum Data Set (MDS) assessment dated 4/25/19 indicated her cognition was severely impaired. Review of Resident #84 ' s record indicated she had Medicare covered Part A Services from 7/9/19 through 7/12/19 and remained in the facility when the coverage for her Part A Services ended. The record revealed Resident #84 ' s Responsible Party (RP) signed the Notice of Medicare Non-Coverage (NOMNC/CMS-10123) on the same day that her coverage for Part A	F 582	F- 582 The following will be accomplished for residents having been affected by the practice: During the survey we were unable to locate copies of these Notice of Medicare Non-Coverage (NOMNC) and Skill Nursing Facility Advanced Beneficiary Notice (SNF ABN). Resident #76 remains at the facility and the skilled services ceased on 8-21-19. Resident #84 was discharged 10-6-19 Resident #85 was discharged 6-21-19. The following has been accomplished for those residents with potential to be affected by the practice: On 11/13/19, an audit was conducted by the Social Worker and Business Office Manager on current residents who remained in the facility after skilled services (Part A) ceased to ensure the NOMNC and SNF ABN was issued. No other issues were identified after audit completion. The following measures have been put in place to ensure that the practice does not recur: On 11/13/19, the Administrator provided education to the Social Worker and Business Office Manager on the process for issuing NOMNC and SNF ABN as follows: The Social Worker will be responsible for	

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F 582	Continued From page 7 services ended (7/12/19). The record also revealed that a Skilled Nursing Facility Advanced Beneficiary Notification (SNF ABN/CMS-10055) was not provided to Resident #84 or her RP when her coverage for Part A services ended (7/12/19). An interview was conducted with the Administrator on 10/22/19 at 3:30 PM. She stated that the former Administrator was responsible for providing the beneficiary notifications to the resident and/or Responsible Party (RP). She revealed they had no record that a SNF ABN was provided to Resident #84 and that the NOMNC was provided outside of the required timeframe. She stated that she expected the regulations regarding beneficiary notifications to be followed and that she was already in the process of completing an action plan to correct the issue. 3. Resident #85 was admitted to the facility on 5/17/19 and most recently readmitted on 6/1/19. The admission Minimum Data Set (MDS) assessment dated 5/24/19 indicated her cognition moderately impaired. Review of Resident #85 ' s record indicated she had Medicare covered Part A Services from 6/1/19 through 6/20/19. The record revealed Resident #85 was not provided with a Notice of Medicare Non-Coverage (NOMNC/CMS-10123) when her coverage for Part A services ended (6/20/19). An interview was conducted with the Administrator on 10/22/19 at 3:30 PM. She stated that the former Administrator was responsible for providing the beneficiary notifications to the resident and/or Responsible	F 582	issuing the NOMNC and SNF ABN forms to the resident/responsible party when notified by the insuring entity that skilled services will be ending. After issuing the NOMNC and SNF ABN and receiving a signed receipt, the notice will be forwarded to the Business Office Manager who maintains documentation for billing. The Business Office Manager is responsible for ensuring that the NOMNC and SNF ABN has been issued and a copy is maintained in the business office file. The Business Office manager will maintain a log of all residents on a skilled benefit. The log will include the date of admission, a grid to indicate days used under the benefit, date coverage ends, date NOMNC and SNF ABN issued and date a copy was provided for the business office file. The following monitoring system will be implemented to ensure that the solution is sustained: The Administrator will audit the NOMNC/ SNF ABN log weekly indicating the review with date and initials. This audit will continue for six weeks or until a pattern of compliance is maintained. Results of the audit will be reported to the Quality Assurance and Improvement Committee monthly for evaluation. The plan will be revised as deemed necessary.	

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F 582	Continued From page 8 Party (RP). She revealed they had no record that a NOMNC was provided to Resident #85. She stated that she expected the regulations regarding beneficiary notifications to be followed and that she was already in the process of completing an action plan to correct the issue.	F 582		
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		11/21/19

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F 584	Continued From page 9 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interview, the facility failed to provide a sufficient supply of wash cloths, towels, and clothing protectors to meet the needs of the residents on 4 of 4 halls. The findings included: Review of the monthly Resident Council meeting minutes dated 8/26/19 and 9/30/19 included, in part, a concern with the facility not having enough clothing protectors for the residents at meal time. Review of the monthly Resident Council meeting minutes dated 9/30/19 included, in part, a concern with the facility not having enough clothing protectors for the residents at meal time. A Resident Council meeting was conducted on 10/23/19 at 10:00 AM with 4 alert and oriented residents who were active participants in the facility's Resident Council. They reported concerns with the facility not having enough linens available. They indicated that this included clothing protectors, wash cloths, and towels. The residents stated that they had discussed the issue with the clothing protectors in the Resident	F 584	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F- 584 The following was accomplished for residents affected by the practice and for those with potential to be affected by the practice: To ensure an adequate supply of linen, four dozen clothing protectors, seven dozen towels, twenty-five dozen wash clothes, five dozen fitted sheets and eight dozen underpads were ordered on	

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F 584	Continued From page 10 Council meetings, but they had not discussed the issue with wash cloths and towels. An interview was conducted with Nursing Assistant (NA) #1 on 10/23/19 at 11:05 AM. She confirmed that the facility had an issue with wash cloths and towels being available. She reported that this was a frequent occurrence and that it was worse in the morning, but progressively got better as the day went on. She stated that this has been an issue for at least 3 months. NA #1 reported that if there were no linens on the cart they would have to go to the laundry room and see if there was anything clean that had not been placed on the cart, use a disposable towel, or wait until the laundry was done to complete their task. She indicated that the Housekeeping Manager was aware of the issue. An interview was conducted with Nurse #2 on 10/23/19 at 11:08 AM. She confirmed that the facility had an issue with wash cloths and towels being available. She indicated it was a frequent occurrence and that it had been going on for at least 3 months. She stated that the Housekeeping Manager was aware of the issue. An interview was conducted with Nurse #3 on 10/23/19 at 11:09 AM. She confirmed that the facility had an issue with wash cloths and towels being available. She indicated it was a frequent occurrence and that it had been going on for at least 3 months. She stated that the Housekeeping Manager was aware of the issue. An interview was conducted with Nurse #4 on 10/23/19 at 11:10 AM. She confirmed that the facility had an issue with wash cloths and towels being available. She indicated it was a frequent	F 584	October 23 and, October 24, 2019 and were received and processed on October 25, 2019. Another order was placed on October 30, 2019 and received on 11-1-2019. The following measures were put in place to ensure that adequate supply linen is available: The contract service has established linen par levels which are to be available on specific units each shift. The facility has approved these levels. Linen will continue to be purchased to maintain the par levels. The following was put in place to monitor the performance and ensure that the corrective action is sustained: The Director of Laundry or designee, to ensure adequate linen is always available based on an established par levels, will audit the supply of linens on each linen cart on each shift daily for two weeks and weekly t hereafter for four weeks or until a pattern of compliance has been established. The results of these audits will be presented to the Quality Assurance and Improvement Committee for review. The plan will be revised as deemed necessary.	

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F 584	Continued From page 11 occurrence and that it had been going on for at least 3 months. She stated that the Housekeeping Manager was aware of the issue. An interview was conducted with the Activities Director on 10/23/19 at 12:00 PM. She stated that the residents had discussed an issue with the facility not having enough clothing protectors during the August 2019 and September 2019 Resident Council meetings. An interview was conducted with the Housekeeping Manager and her supervisor, the District Leader, on 10/23/19 at 12:47 PM. The Housekeeping Manager acknowledged she was aware of a concern with the facility not having enough clean clothing protectors available at meal time. She stated that this was an issue with the laundry being washed and dried quickly enough between meals rather than not having a sufficient supply. She indicated that one of her laundry staff had quit a few weeks ago, a new one started last week, and then someone else quit this week which could have contributed to this issue. The Housekeeping Manager also acknowledged she was aware of a concern with the facility not having enough wash cloths and towels. She revealed that she had just ordered some additional towels and wash cloths today as she noticed that they were running low. She stated that she believed part of the issue was with staff throwing the wash cloths and/or towels away rather than putting them in the laundry to be cleaned. An interview was conducted with the Administrator on 10/24/19 at 12:01 PM. She stated that she expected the facility to maintain a sufficient supply of clean clothing protectors,	F 584		

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F 584	Continued From page 12 wash cloths, and towels to meet the needs of the residents.	F 584		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of cognition (Residents #15 and #49), mood (Residents #15 and #49), and medications (Resident #79) for 3 of 19 sampled residents. The findings included: 1. Resident #15 was most recently admitted to the facility on 5/11/17 with diagnoses that included dementia. A nursing note dated 8/6/19 indicated Resident #15 was alert and verbal with speech clear to mumbled. She was noted to have delayed responses with difficulty finding words and finishing thoughts. A note dated 8/9/19 completed by Minimum Data Set (MDS) Nurse #2 indicated the Brief Interview for Mental Status (BIMS) and resident mood interview were attempted with Resident #15. This note revealed that Resident #15 was alert and verbal and spoke a few understandable words which were unrelated to the questions asked.	F 641	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F- 641 The following has been accomplished for Residents #15, #49 and #79 who were affected by the practice: Their assessments have been modified by the Minimum Data Set (MDS) Coordinator to accurately reflect their current status. The modification for resident #79 was completed on 10-24-19 and the modifications for resident #15 and #49 was completed on 11-13-19. The	11/21/19

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Continued From page 13

The significant change MDS assessment dated 8/9/19 indicated Resident #15 was not in a persistent vegetative state. Section C (Cognitive Patterns section) and Section D (Mood section), were coded to indicate Resident #15 was rarely/never understood and that the BIMS and the resident mood interview were not conducted. Sections C and D were completed by MDS Nurse #2.

An interview was conducted with Resident #15 on 10/23/19 at 10:30 AM. Resident #15 stated her name and she asked, "Are you looking for someone?".

An interview was conducted with the MDS Coordinator on 10/24/19 at 9:05 AM. She reported that MDS Nurse #2 worked part time at the facility. She reported that she was comfortable answering questions related to MDS coding completed by MDS Nurse #2. The 8/9/19 MDS for Resident #15 that indicated the BIMS and resident mood interview were not conducted for this resident because she was rarely/never understood was reviewed with the MDS Coordinator. The note dated 8/9/19 completed by MDS Nurse #2 that indicated the BIMS and the resident mood interview had been attempted with Resident #15 was reviewed with the MDS Coordinator. The MDS coordinator revealed that based on the Resident Assessment Instrument (RAI) manual this 8/9/19 MDS for Resident #15 was coded inaccurately in the areas of cognition and mood.

An interview was conducted with the Administrator and the Assistant Director of Nursing on 10/24/19 at 12:01 PM. They both indicated they expected the MDS to be coded

F 641

residents did not experience a negative outcome related to these findings.

The following will be accomplished for residents with potential to be affected by this practice:

By 11/21/19, an audit of all MDS assessments for the past 30 days will be conducted by the MDS Coordinator or designee to ensure accurate coding of sections C, D, and N. All negative findings will be corrected with the completion of a modification for each discrepancy identified on the most current MDS assessment.

The following measures will be put in place to ensure that the practice does not recur:

The social worker, MDS coordinators, and activity director and any Interdisciplinary Team(IDT) member involved in the completion of the MDS will by educated by the Regional MDS Consultant by November 21, 2019 on the facility policy related to the accurate completion of the MDS including sections C, D, and N.

The following was put in place to monitor the performance and ensure that the corrective action is sustained:

The MDS Coordinator or designee will audit the accuracy of sections C, D, and N for 50% of the previous weeks' completed assessments to ensure accuracy of coding utilizing the MDS Accuracy Audit

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F 641	Continued From page 14 accurately. 2. Resident #49 was admitted to the facility on 6/24/15 with diagnoses that included Alzheimer ' s Disease. A nursing note dated 9/8/19 indicated Resident #49 was alert and verbal with speech in and out of context. A nursing note dated 9/11/19 indicated Resident #49 occasionally rambled on with non-sensical statements and disorganized thoughts with her words being unrelated to questions asked. A noted dated 9/12/19 completed by Minimum Data Set (MDS) Nurse #1 indicated the Brief Interview for Mental Status (BIMS) and resident mood interview were attempted with Resident #49, but she had not responded to any questions. The quarterly MDS assessment dated 9/12/19 indicated Resident #49 was not in a persistent vegetative state. Section C (Cognitive Patterns section) and Section D (Mood section), were coded to indicate Resident #49 was rarely/never understood and that the BIMS and the resident mood interview were not conducted. Sections C and D were completed by MDS Nurse #1. An interview was conducted with MDS Nurse #1 on 10/24/19 at 9:05 AM. The 9/12/19 MDS for Resident #49 that indicated the BIMS and resident mood interview were not conducted for this resident because she was rarely/never understood was reviewed with MDS Nurse #1. The note dated 9/12/19 that indicated the BIMS and the resident mood interview had been attempted with Resident #49 was reviewed	F 641	form. Negative findings will be corrected with completion of a modification. The audit will continue for six weeks or until a pattern of compliance is established. The results of this audit will be presented to the Quality Assurance and Improvement Committee for evaluation. The plan will be revised as deemed necessary.	

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F 641	Continued From page 15	F 641		

with MDS Nurse #1. MDS Nurse #1 revealed that based on the Resident Assessment Instrument (RAI) manual this 9/12/19 MDS for Resident #49 was coded inaccurately in the areas of cognition and mood.

An interview was conducted with the Administrator and the Assistant Director of Nursing on 10/24/19 at 12:01 PM. They both indicated they expected the MDS to be coded accurately.

3. Resident #79 was admitted to the facility on 6/19/18 with diagnoses that included dementia.

A physician ' s order for Resident #79 dated 10/10/19 indicated Augmentin (antibiotic) 875 milligrams (mg) every 12 hours for 10 days and Ciprodex Otic (antibiotic ear drop) twice daily for 7 days.

A note dated 10/15/19 completed by Minimum Data Set (MDS) Nurse #1 indicated Resident #79 was currently receiving an antibiotic.

The quarterly MDS assessment dated 10/15/19 indicated Resident #79 ' s cognition was severely impaired. The Medications section, Section N, of this MDS indicated Resident #79 had received no antibiotic medication during the 7-day MDS look back period (10/9/19 through 10/15/19). Section N of the 10/15/19 MDS for Resident #79 was coded by MDS Nurse #1.

A review of the October 2019 Medication Administration Record (MAR) for the 10/15/19 MDS look back period (10/9/19 through 10/15/19) indicated Resident #79 had received antibiotic medication on 6 of 7 days (10/10/19 through

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F 641	Continued From page 16 10/15/19). An interview was conducted with MDS Nurse #1 on 10/24/19 at 9:50 AM. The 10/15/19 MDS for Resident #79 that indicated he had received no antibiotics during the MDS look back period was reviewed with MDS Nurse #1. The MAR that indicated Resident #79 had received antibiotics on 6 of 7 days during the 10/15/19 look back period was reviewed with MDS Nurse #1. MDS Nurse #1 confirmed this MDS was inaccurate. She revealed that this was en error and she would complete a modification. An interview was conducted with the Administrator and the Assistant Director of Nursing on 10/24/19 at 12:01 PM. They both indicated they expected the MDS to be coded accurately.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required	F 656		11/21/19

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F 656	Continued From page 17 under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review, the facility failed to develop and implement a person-centered care plan for activities for 2 (Resident #11 and Resident #74) of 2 residents reviewed for activities. The findings included: 1. Resident #11 was admitted on 10/5/16 with a diagnosis of Dementia. Resident #11's annual Minimum Data Set (MDS) indicated she had severe cognitive impairment and exhibited physical behaviors directed towards	F 656	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be	

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F 656 Continued From page 18

self and other, but she exhibited no verbal behaviors. Resident #11's section F titled "Preferences for Customary Routine and Activities" indicated this section was completed with the assistance of her family. It read the following: doing things with groups of people, religious and going outside were very important to her. She was coded as using a wheelchair for mobility and unable to ambulate.

Resident #11's activities care plan last revised on 7/30/19 read per her family she had preferences of music, spiritual/religious programs, time outdoors and socials. The goal was for Resident #11 to participate in activities of her preference twice per week. Interventions included provide transportation to and from activities of interest, encourage and praise activity attendance, post personal activity calendar in her room, invite and encourage her to participate in activity groups of targeted interest like music, spiritual/religious programs and time outdoors.

There were no observed activities in progress in the dementia unit on 10/21/19 at 9:45 AM, 10:30 AM or 3:30 PM.

In an observation of the dementia unit on 10/22/19 at 9:45 AM Resident #11 was observed sitting in the hallway along with 14 other residents. There were no observed activities in progress.

In an observation of the dementia unit on 10/22/19 at 10:30 AM Resident #11 was observed sitting in the hallway along with 14 other residents. There were no observed activities in progress.

F 656

completed by the dates indicated.

F-656

The following was accomplished for residents #11and resident #74 who were affected by the practice.

The care plans were reviewed and revised on November 13, 2019 by the Director of Activities based on current and previous interests and strengths and limitations as assessed on the Minimum Data Set (MDS) to ensure that the care plans are person centered and that the plan is individualized and implemented.

The following will be accomplished for other residents having the potential to be affected by the practice:

All resident care plans on the special Memory Care unit will be reviewed evaluated and revised by November 21, 2019 by the Director of Activities to ensure that the care plans are person-centered and implemented. The plans will reflect past and current interests and strengths and limitations noted on the MDS.

The following measures will be put in place to ensure the practice does not recur:

The Activity Director will educate the Activity Staff responsible for programming by 11-21-19 on the Memory Care unit on how to create a person-centered plan of

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In an observation of the dementia unit on 10/22/19 at 11:15 AM Resident #11 was observed sitting in the hallway along with 14 other residents. There were no observed activities in progress.

In an observation of the dementia unit on 10/23/19 at 8:35 AM, Resident #11 was observed sitting in the hallway along with 8 other residents. Resident #11 was napping.

In an observation of Resident #11's room on 10/23/19 at 8:45 AM, the personal activity calendar was observed pinned to a cork board over the head of her bed at eye level while standing.

In an observation of the dementia unit on 10/24/19 at 9:30 AM, Resident #11 was observed self-propelling her wheelchair out of her room into the hallway repeating "what can I do now?". There was observed 10 other residents sitting in the hallway. Observed in the hallway near the nursing station was a large bulletin board activity calendar which read there would be a birthday party in the main dining room at 10:30 AM.

In an observation of the main dining room on 10/24/19 at 10:30 AM, Resident #11 was not observed in attendance.

In an observation of the dementia unit on 10/24/19 at 10:35 AM, Resident #11 was observed self-propelling in her wheelchair repeating "what can I do?".

F 656

care, resources utilized to develop the care plan and the process of implementation.

The following monitoring initiative will be implemented to ensure the solutions are sustained.

The Activity Director will audit and approve all Activity Care Plans developed by the Activity staff. The audit form will include resident name, date of activity care plan reviewed. The activity attendance log will be audited to ensure that the care plan has been implemented. The Activity Director will audit 25% of activity care plans and implementation weekly for six weeks or until a pattern of compliance has been established. The results of the audits will be presented to the Quality Assurance and Improvement Committee for review and evaluation. The plan will be revised as deemed necessary.

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An interview on was conducted on 10/24/19 at 11:14 AM with the AD and Assistant Activity Director (AAD). The AD stated she had been in her position for approximately one year and the AAD stated she had been in her position since last spring and was trained by the AD. The ADD stated she was responsible for activities on the dementia unit and stated she completed the activity care plans for residents on the dementia unit but stated it was new to her.

Interview on 10/24/19 at 11:38 AM, the Administrator stated Resident #11's activity care plan should be person centered and implemented.
2. Resident #74 was admitted to the facility on 7/13/18 with diagnoses that included dementia without behavioral disturbance.

Resident #74 ' s 7/17/19 annual review for activities was completed by the Activity Director (AD). This review indicated that Resident #74 was alert and up in her wheelchair daily. She was able to make eye contact when spoken to. Resident #74 required reminders, encouragement, and assistance to attend out of room activities. She was noted to have family assist with the completion of her activity assessment. Resident #74 had attended the following activities: games, crafts, spiritual/religious, music, bingo, and exercise. The AD indicated in Resident #74 ' s leisure time she listened to music, watched tv/movies, talked to other residents, went outdoors when the weather was nice, and had visits from her family and friends. Staff were to continue to encourage Resident #74 to attend activities of interest.

The annual Minimum Data Set (MDS)

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assessment dated 7/18/19 indicated Resident #74 ' s cognition was severely impaired. She was assessed with impaired vision, able to see large print but not regular print in newspapers/books and had corrective lenses. She had verbal behaviors daily and experienced delusions during the 7-day MDS review period. Section F, Preferences for Customary and Routine Activities, indicated it was very important to Resident #74 to have books/magazines/newspapers to read, listen to music she liked, be around animals such as pets, do things with groups of people, do her favorite activities, go outside to get fresh air when the weather was good, and participate in religious services/practices. Resident #74 required the extensive assistance of 1 for locomotion on the unit and dependent on 1 for locomotion off the unit. She utilized a wheelchair and walker.

Resident #74 ' s care plan included the problem/need of being unable to verbalize her preferences and that her family reported she enjoyed cards, games, crafts, exercise, music, reading, baking/cooking, spiritual/religious activities, watching tv/movies, gardening/plants, talking/conversing, fishing, parties/social events, and community outings. This problem/need was initiated on 7/17/19 and last reviewed on 10/9/19 by the Assistant Activities Director (AAD). The goal for this problem/need was for Resident #74 to participate in at least 1 out of room activity per week and to increase participation in activities.
The interventions were as follows:
- Ask about my activity preferences and help me plan
- I enjoy reading books, magazines, and newspapers
- I love to be around animals
- I prefer activities that involve music

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F 656	Continued From page 22 - Please assist me to get to the activities I choose - Please remind me when my activities are scheduled - Post personal activity schedule in [Resident #74 ' s] room - Transport resident to activities and facility functions There were no observed activities in progress in the dementia care unit on 10/21/19 at 9:45 AM, 10:30 AM or 3:30 PM. An interview was conducted with Resident #74 on 10/21/19 at 3:31 PM. She was on the dementia care unit, seated in her wheelchair sitting in the door way of her room facing the hallway. She was alert and oriented to self. Resident #74 stated, "What am I supposed to do ...I need something to do ...it ' s just making me crazy." The resident reported that she was always busy during her lifetime and never had downtime, so she didn ' t know what to do with her downtime. She indicated she was a homemaker during her life and she enjoyed cooking, cleaning, animals, music, and church. Observations conducted of the dementia care unit on 10/22/19 at 9:45 AM, 10:30 AM, and 11:30 AM, revealed Resident #74 seated in her wheelchair in the hallway along with 14 other residents. The residents were lined up against the walls of the hallway facing each other. Several residents were observed to be sleeping. There were no observed activities in progress and no interactions observed between staff and residents. Resident #74 ' s room was observed on 10/23/19 at 8:55 AM. An activity calendar was posted on	F 656		

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F 656	Continued From page 23	F 656		

the wall side of her bed on a bulletin board at a height that was eye level when standing. The print on the calendar was regular sized as in newspapers and/or books.

In an observation of the dementia care unit on 10/23/19 at 2:41 PM Resident #74 was observed seated in her wheelchair in the hallway along with 7 other residents. The residents were lined up against the walls of the hallway facing each other. Several residents were observed to be sleeping. There were no observed activities in progress and no observed interactions between staff and residents.

An interview was conducted with Nurse #1 on 10/24/19 at 9:55 AM. She stated that the AAD was in charge of providing activities to the residents on the dementia care unit. Nurse #1 reported that she had not seen any activities on the dementia care unit when she was working on 10/23/19. She reported that Resident #74 was very sociable and enjoyed attending activities.

An interview was conducted on 10/24/19 at 11:14 AM with the AD and AAD. The AD stated she had been in her position for approximately one year and the AAD stated she had been in her position since last spring. The AAD reported she was responsible for activities on the dementia care unit and was trained by the AD. She additionally reported that she was responsible for care plans related to activities, but that she was new to the care panning process. Resident #74 ' s care plan related to activities that indicated the goal of attending 1 activity per week was reviewed with the AAD. The AAD revealed that this was not a person-centered goal for Resident #74 as she was very social and 1 activity per

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F 656	Continued From page 24 week was not enough for her. The care plan intervention of posting Resident #74 ' s personal activity calendar in her room was reviewed with the AAD. The placement of Resident #74 ' s activity calendar at a height that was at eye level when standing, Resident #74 ' s inability to stand independently, and her impaired vision were reviewed with the AAD. She acknowledged that Resident #74 would not have been able to see what was printed on this activity calendar. The following care plan interventions were reviewed with the AAD: - I enjoy reading books, magazines, and newspapers - I love to be around animals - I prefer activities that involve music The AAD acknowledged that these were not actual interventions that were able to be implemented. She indicated that a appropriate interventions would have been to take Resident #74 to musical activities, animal activities, and reading activities. An interview was conducted on 10/24/19 at 11:38 AM with the Administrator. She indicated that her expectation was for care plans to be person centered, to address the strengths and limitations of the residents, and to be consistently implemented.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 677		11/21/19

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F 677	Continued From page 25 Based on observations, staff interviews and record review, the facility failed to provide nail care for resident's dependent of staff assistance with activities of daily living (ADLs) with hand contractures. This was for 2 (Resident #24 and Resident #46) of 2 residents reviewed for ADLs. The findings included: 1. Resident #24 was admitted on 7/25/14 with bilateral hand contractures. Resident #24's quarterly Minimum Data Set (MDS) dated 8/15/19 indicated moderate cognitive impairment and she exhibited no behaviors. She was coded for extensive staff assistance with her personal hygiene and coded for bilateral upper extremity impairment. Review of Resident #24's care plan dated 6/22/18 read she needed help with her ADLs related to decreased use of both hands. Interventions included one-person assistance with grooming and personal hygiene. Review of Resident #24's care plan dated 5/31/19 read she required right-hand and left-hand splints related to hand contractures. Interventions included to assess her skin integrity for compromise. Review of Resident #24's October 2019 Physician orders included an order dated 1/7/19 which read: Apply sheep orthotic hand splints at night and remove in the morning. Monitor for skin irritation, bruising or skin breakdown. Review of Resident #24's undated electronic care-guide the nursing assistants (NA) follow when providing care read: Donn sheep orthotic	F 677	This Plan of Correction constitutes a written allegation of compliance. Preparation and submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted solely because of the requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. F677 IMMEDIATE ACTION On 10/22/2019 the fingernails of Resident #24 and Resident #46 were cleaned and trimmed by staff. IDENTIFICATION OF OTHERS On 10/ 22/ 2019, the Director of Nursing or Unit Coordinators audited 100% of all residents with hand contractures. Care plans for all identified residents since 10/22/2019 have been updated by MDS Coordinator to reflect nail care needs and care preferences. On 11/ 13/ 2019, the Director of Nursing or Unit Coordinator reviewed the Activities of Daily Living (ADL) care plans and audited 100% of dependent residents with no further issues identified. SYSTEMIC CHANGES	

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hand splints at night and remove in the morning. Monitor for skin irritation, bruising or skin breakdown.

Review of Resident #24's electronic NA documentation from 10/1/19 to 10/22/19 revealed documented evidence of the aides applying her hand splints at bedtime and removing them in the morning. The electronic NA documentation from 10/1/19 to 10/22/19 also revealed Resident #24 required limited to total assistance with her personal hygiene.

Review of the October 2019 activity calendar read "nifty nails" was done on 10/8/19. Review of Resident #24's activity attendance sheet indicated #24 was in attendance.
Observation on 10/21/19 at 12:25 PM, Resident #24 was sitting in her wheelchair in the main dining room. She had severe bilateral hand contractures with long, jagged fingernails painted pink. Her fingernails were noted pressing into her palms. There was no observed evidence of skin breakdown.

Observation on 10/22/19 at 9:47 AM, Resident #24 was in her wheelchair sitting in the day room. She had severe bilateral hand contractures with long, jagged fingernails painted pink. Her fingernails were noted pressing into her palms and voiced no discomfort. There was no observed evidence of skin breakdown.

In an interview on 10/22/19 at 3:45 PM, the Activity Director (AD) stated during "nifty nails" residents' fingernails were trimmed, filed and painted. She confirmed Resident #24 was in attendance on 10/8/19.

Effective 11/15/2019, all identified residents with hand contractures will be monitored weekly for nail care needs. Any identified resident with hand contractures will receive timely nail care as needed. Audit forms will be utilized by the Director of Nursing and Unit Coordinators to track and monitor identified dependent residents nail care.

MONITORING PROCESS

Effective 11/15/2019, the Director of Nursing and Unit Coordinators will monitor compliance by reviewing all audit forms to ensure the initiation and completion of nail care for identified residents. Compliance monitoring will occur weekly for 8 weeks, then bi-weekly for 4 weeks or until a pattern of compliance is maintained. The QAPI Committee can modify this plan to ensure that the facility remains in substantial compliance.

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In an interview on 10/22/19, NA #5 confirmed she was assigned Resident #24 and stated this was her first day back after a month of leave. Resident #24 was in bed when NA #5 assessed her fingernails and agreed they were too long and there was potential for skin breakdown if her fingernails were not trimmed. NA #5 stated when she last worked with Resident #24, her daughter liked to come in and paint Resident #24's fingernails but since it was her first day back, she had not seen her daughter but thought she visited daily. She stated she would let her daughter know her fingernails needed to be trimmed to prevent skin breakdown.

In an interview on 10/22/19 at 4:15 PM, the Administrator stated it was her expectation that Resident #24's fingernail be addressed immediately, and she expected her fingernails and hands to be assessed daily for any skin concerns such has skin breakdown, hand hygiene and long, jagged fingernails.

Observation on 10/23/19 at 11:45 AM, Resident #24 was in her wheelchair sitting in the day room. Her fingernails were trimmed and filed. She reported the staff trimmed her fingernails on 10/22/19.

2. Resident #46 was admitted on 4/25/13 with cumulative diagnoses of Cerebral Vascular Accident and a left-hand contracture.

Review of Resident #46's care plan dated 12/21/18 for refusal of activities of daily living (ADLs) included the intervention of staff re-approach for refusals.
Review of Resident #46's care plan dated 6/2/18

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read she required splint application to maintain or improve her left-hand contracture. Interventions included donning her resting left-hand splint at night and removing it in the morning. Staff were to monitor for skin irritation or redness.

Review of Resident #46's care plan dated 1/11/19 read she had a self-care deficit and required staff assistance with grooming and personal hygiene. Interventions included staff providing grooming and hygiene assistance.

Resident #46's quarterly Minimum Data Set (MDS) dated 9/9/19 indicated moderate cognitive impairment with a behavior of rejection of care. She was coded for total staff assistance with her personal hygiene and coded for impairment on one side to her upper extremity.

Review of Resident #46's October 2019 Physician orders included an order dated 6/2/18 which read: Please put on left resting hand splint on at night and remove in the morning. Monitor for skin irritation and redness.

Review of Resident #46's undated electronic care-guide the nursing assistants (NA) follow when providing care read: Donn left resting hand splint at bedtime and remove in in the morning. Monitor for skin irritation and redness.

Review of Resident #46's electronic NA documentation from 10/1/19 to 10/22/19 revealed documented evidence of the aides applying her left-hand splint at bedtime and removing it in the morning. The electronic NA documentation from 10/1/19 to 10/22/19 also revealed Resident #24 required total assistance with her personal hygiene.

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Observation on 10/21/19 at 12:25 PM, Resident #46 was sitting in her wheelchair in the main dining room. She had a severe left-hand middle finger contracture. Her fingernails were long and jagged and pushing into her palm. She voiced no pain. There was no observed evidence of skin breakdown.

Observation on 10/22/19 at 11:20 AM, Resident #46 was sitting up in her wheelchair in her room. She had a severe left-hand middle finger contracture. Her fingernails were long and jagged and pushing into her palm. She voiced no pain. There was no observed evidence of skin breakdown.

In an interview on 10/22/19 at 3:50 AM, NA #6 confirmed she was assigned Resident #46 on 10/21/19 and 10/22/19 on second shift. NA #6 stated she always assessed her fingernails before applying her left-hand splint at night.

In an interview and observation on 10/22/19 at 4:10 PM, NA #6 was in Resident #46's room. Resident #46 stated "I thought someone was going to was going to cut my fingernails yesterday." NA #6 responded to Resident #46 that she forgot to do them yesterday when she gave her a shower.

In an interview on 10/22/19 at 4:15 PM, the Administrator stated it was her expectation that Resident #46's fingernail be addressed immediately, and she expected her fingernails and hands to be assessed daily for any skin concerns such has skin breakdown, hand hygiene and long, jagged fingernails.

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F 677	Continued From page 30 Observation on 10/23/19 at 12:10 PM, Resident #46 was in her wheelchair sitting in the hallway outside of her room. Her fingernails were trimmed and filed. She reported the staff trimmed her fingernails on 10/22/19.	F 677		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident interview, and staff interview, the facility failed to provide an ongoing resident centered activities program that included group activities and/or 1 on 1 activities based on the strengths and limitations of individual residents on the dementia care unit for 2 of 2 sampled residents reviewed for activities (Residents #11 and #74). The findings included: 1. Resident #74 was admitted to the facility on 7/13/18 with diagnoses that included dementia without behavioral disturbance. Resident #74 ' s 7/17/19 annual review for activities was completed by the Activity Director	F 679	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F- 679	11/21/19

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F 679	Continued From page 31 (AD). This review indicated that Resident #74 was alert and up in her wheelchair daily. She was able to make eye contact when spoken to. Resident #74 required reminders, encouragement, and assistance to attend out of room activities. She was noted to have family assist with the completion of her activity assessment. Resident #74 had attended the following activities: games, crafts, spiritual/religious, music, bingo, and exercise. The AD indicated in Resident #74 ' s leisure time she listened to music, watched tv/movies, talked to other residents, went outdoors when the weather was nice, and had visits from her family and friends. Staff were to continue to encourage Resident #74 to attend activities of interest. The annual Minimum Data Set (MDS) assessment dated 7/18/19 indicated Resident #74 ' s cognition was severely impaired. She had verbal behaviors daily and experienced delusions during the 7-day MDS review period. Section F, Preferences for Customary and Routine Activities, indicated it was very important to Resident #74 to have books/magazines/newspapers to read, listen to music she liked, be around animals such as pets, do things with groups of people, do her favorite activities, go outside to get fresh air when the weather was good, and participate in religious services/practices. Resident #74 required the extensive assistance of 1 for locomotion on the unit and dependent on 1 for locomotion off the unit. She utilized a wheelchair and walker. Resident #74 ' s care plan included the problem/need of being unable to verbalize her preferences and that her family reported she enjoyed cards, games, crafts, exercise, music, reading, baking/cooking, spiritual/religious	F 679	The following was accomplished for resident #11and resident #74 who were affected by the practice: Based on past interests, current interests, and the MDS assessment, the care plans and activity programming of both resident #11 and resident #74 were revised by the Director of Activities to reflect current status on 11-14-19. The following will be accomplished for other residents having the potential to be affected by the practice: By 11/21/19, all care plans for residents on the Memory Care unit will have their care plans reviewed and revised as needed by the Activity Director. Care plans and the residents' activity programing will be based on current and past interests and strengths and limitations assessed on the MDS. On 11/13/19, the Administrator (a former Activities Director Consultant) educated the Activities Director and Activity Staff on formulating resident centered activity programs that include group activities and/or 1 on 1 activities based on the strengths and limitations of dementia care residents. Also, additional programming has been added to the Activity schedule on the Memory Care unit to ensure that ongoing resident centered group and individual 1 on 1 are available to residents. Additional programs include 1 on 1 and small group sensory stimulation five mornings weekly; Music and Movement; Name that Sound; Betty says;	

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activities, watching tv/movies, gardening/plants, talking/conversing, fishing, parties/social events, and community outings. This problem/need was initiated on 7/17/19 and last reviewed on 10/9/19. The goal for this problem/need was for Resident #74 to participate in at least 1 out of room activity per week and to increase participation in activities. The interventions included reminding Resident #74 when activities were scheduled, ask about her activity preferences, help plan activities, and to transport her to activities and facility functions.

Resident #74 ' s 10/9/19 quarterly review for activities was completed by the Assistant Activity Director (AAD). This review was identical to the 7/17/19 annual review completed by the AD.

The quarterly MDS assessment dated 10/10/19 indicated Resident #74 ' s cognition was moderately impaired. She had verbal behaviors and other behavioral symptoms on 1 to 3 days and experienced delusions during the 7-day MDS review period. Resident #74 required the extensive assistance of 1 for locomotion on and off the unit and she utilized a wheelchair.

A review of the September 2019 Activity Calendar for the dementia care unit indicated there were 5 scheduled activities that month that were held on the dementia care unit and geared specifically toward the residents on that unit. The remaining activities were held on the main unit and were open to all residents in the facility. There were no activities scheduled on the dementia care unit on any weekend days in September 2019.

A review of Resident #74 ' s September 2019 Activity Attendance Record indicated she

F 679

Complete the adage; What do you do with it; What is it; Card Pairing; Hokey Pokey and Making Music. These activities were designed to address a variety of interests and a range of strengths and limitations for both active and passive participation. Each program will be evaluated for resident participation and interest. Activity programs will be revamped or replaced as needed.

The following measures are being put in place to ensure the practice does not recur:

With the revision of resident activity care plans and programming based on individual interests and strengths and limitations as well as the increased number of activity programs on the schedule, the residents will be provided with ongoing resident centered activities.

The following will be put in place to monitor performance and ensure that the solutions are sustained:

The Director of Activities will review the attendance log weekly for six weeks, or until a pattern of compliance is sustained, of 25% of residents on the Memory Care unit and compare with the care plan to ensure that the plan is implemented and residents are provided with ongoing resident centered activities. The results of this audit will be presented to the Quality Assurance and Improvement Committee for evaluation. The plan will be revised as deemed necessary.

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attended a total of 26 activities with 2 of these activities being held on the dementia care unit. These activities included: bingo (7), games (5), spiritual/religious activities (5), parties/social events (3), music (3), movies (1), cooking (1), exercise (1). Resident #74 was noted with no activity attendance on 4 of 5 weekends in September.

A review of the October 2019 Activity Calendar for the dementia care unit indicated there was 1 scheduled activity that month that was held on the dementia care unit and geared specifically toward the residents on that unit. The remaining activities were held on the main unit and were open to all residents in the facility. There were no activities scheduled on the dementia care unit on any weekend days in October 2019.

A review of Resident #74 ' s October 2019 Activity Attendance Record from 10/1/19 through 10/20/19 indicated she attended a total of 16 activities with 1 of these activities being held on the dementia care unit. These activities included: games (6), bingo (3), spiritual/religious activities (2), music (2), exercise (2), and arts/crafts (1). Resident #74 was noted with no activity attendance on 3 of 3 weekends from 10/1/19 through 10/20/19.

There were no observed activities in progress in the dementia care unit on 10/21/19 at 9:45 AM, 10:30 AM or 3:30 PM.

An interview was conducted with Resident #74 on 10/21/19 at 3:31 PM. She was on the dementia care unit, seated in her wheelchair sitting in the door way of her room facing the hallway. She was alert and oriented to self. Resident #74

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stated, "What am I supposed to do ...I need something to do ...it ' s just making me crazy." The resident reported that she was always busy during her lifetime and never had downtime, so she didn ' t know what to do with her downtime. She indicated she was a homemaker during her life and she enjoyed cooking, cleaning, animals, music, and church.

In an observation of the dementia care unit on 10/22/19 at 9:45 AM Resident #74 was observed seated in her wheelchair in the hallway along with 14 other residents. The residents were lined up against the walls of the hallway facing each other. Several residents were observed to be sleeping. There were no observed activities in progress and no interactions observed between staff and residents.

In an observation of the dementia care unit on 10/22/19 at 10:30 AM Resident #74 was observed seated in her wheelchair in the hallway along with 14 other residents. The residents were lined up against the walls of the hallway facing each other. Several residents were observed to be sleeping. There were no observed activities in progress and no observed interactions between staff and residents.

In an observation of the dementia care unit on 10/22/19 at 11:30 AM Resident #74 was observed seated in her wheelchair in the hallway along with 14 other residents. The residents were lined up against the walls of the hallway facing each other. Several residents were observed to be sleeping. There were no observed activities in progress and no observed interactions between staff and residents.

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On 10/22/19 at 2:40 PM Resident #74 was observed in a musical activity on the main unit of the facility. She was alert and smiling during this observation.

In an observation of the dementia care unit on 10/23/19 at 2:41 PM Resident #74 was observed seated in her wheelchair in the hallway along with 7 other residents. The residents were lined up against the walls of the hallway facing each other. Several residents were observed to be sleeping. There were no observed activities in progress and no observed interactions between staff and residents.

An interview was conducted with Nurse #1 on 10/24/19 at 9:55 AM. She stated that the AAD was in charge of providing activities to the residents on the dementia care unit. Nurse #1 reported that she had not seen any activities on the dementia care unit when she was working on 10/23/19. She reported that Resident #74 was very sociable and enjoyed attending activities.

An interview was conducted on 10/24/19 at 11:14 AM with the AD and AAD. The AD stated she had been in her position for approximately one year and the AAD stated she had been in her position since last spring. The AAD reported she was responsible for activities on the dementia care unit and was trained by the AD. The AAD indicated that sometimes she had activities on the dementia care unit that were not on the activity calendar, such as ball toss and bowling. She reported she hadn ' t scheduled or attempted any activities on the dementia care unit before 10:00 AM due to residents eating breakfast and being busy with getting their activities of daily living (ADLs) completed. She stated that she invited

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residents on the dementia care unit to attend activities on the main unit, but most of the time the residents were sleeping in the wheelchairs in the hallway and she had not wanted to wake them. She further stated if she took residents from the dementia care unit to an activity on the main unit, she had to stay with them during the main unit ' s activity and therefore could not hold an activity on the dementia care unit during that timeframe. The AAD revealed there were no scheduled activities on the dementia care unit on the weekends as she only worked in her AAD role during the week.

An interview was conducted on 10/24/19 at 11:38 AM with the Administrator. She stated that she had just began working as the Interim Administrator at the end of August 2019. She indicated that her expectation was for the activity program to address the strengths and limitations of the facility residents. She explained that some activities on the main unit were appropriate for all residents regardless of their cognitive status and capabilities, but other activities may be more complex and not be appropriate for all residents. She further explained that she expected activities geared toward the residents on the dementia care unit to be held consistently throughout the week and on the weekends.
2. Resident #11 was admitted on 10/5/16 with a diagnosis of Dementia.

Resident #11's annual Minimum Data Set (MDS) dated 7/30/19 indicated she had severe cognitive impairment and exhibited physical behaviors directed towards self and other. She not coded for any verbal behaviors. Resident #11's section F titled "Preferences for Customary Routine and Activities" indicated this section was completed

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with the assistance of her family. It read the following: doing things with groups of people, religious and going outside were very important to her. She was coded as using a wheelchair for mobility and unable to ambulate.

Review of an Activity note completed by the Activity Director (AD) dated 7/30/19 at 3:55 PM read as follows: Resident #11 was active in the facility environment and attended activities on and off the dementia unit. She attended with reminders, encouragement and assistance to and from all activities. Resident #11 attended religious, social, music and exercise programs. Staff would continue to monitor her activity attendance and continue to remind, encourage and assist to activities of interest. During Resident #11's leisure time, she watched television, listened to music and family visited daily.

Resident #11's activities care plan last revised on 7/30/19 read per her family she had preferences of music, spiritual/religious programs, time outdoors and socials. The goal was for Resident #11 to participate in activities of her preference twice per week. Interventions included provide transportation to and from activities of interest, encourage and praise activity attendance, post personal activity calendar in her room, invite and encourage her to participate in activity groups of targeted interest like music, spiritual/religious programs and time outdoors.

Resident #11's care plan for depression dated 8/9/19 read she was tearful at times associated with anxiety. Interventions read as follows: staff were to console Resident #11 when she was anxious, and she exhibited a verbal behavior of

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F 679	Continued From page 38 questioning "what am I supposed to do now?" Resident #11 "responds well to sunshine and light with gentle conversation." There were no observed activities in progress in the dementia unit on 10/21/19 at 9:45 AM, 10:30 AM or 3:30 PM. In an observation of the dementia unit on 10/22/19 at 9:45 AM Resident #11 was observed sitting in the hallway along with 14 other residents. There were no observed activities in progress. In an observation of the dementia unit on 10/22/19 at 10:30 AM Resident #11 was observed sitting in the hallway along with 14 other residents. There were no observed activities in progress. In an observation of the dementia unit on 10/22/19 at 11:15 AM Resident #11 was observed sitting in the hallway along with 14 other residents. There were no observed activities in progress. In an observation of the dementia unit on 10/23/19 at 8:35 AM, Resident #11 was observed sitting in the hallway along with 8 other residents. Resident #11 was napping. In an observation of Resident #11's room on 10/23/19 at 8:45 AM, the personal activity calendar was observed pinned to a cork board over the head of her bed at eye level while standing.	F 679		

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In an observation of the dementia unit on 10/24/19 at 9:30 AM, Resident #11 was observed self-propelling her wheelchair out of her room into the hallway repeating "what can I do now?". There was observed 10 other residents sitting in the hallway. Observed in the hallway near the nursing station was a large bulletin board activity calendar which read there would be a birthday party in the main dining room at 10:30 AM. There was only one listed activity on the calendar for residents on the dementia unit dated 10/17/19 titled "balloon stamping". All other activities were indicated as being on the main unit.

In an observation of the main dining room on 10/24/19 at 10:30 AM, Resident #11 was not observed in attendance.

In an observation of the dementia unit on 10/24/19 at 10:35 AM, Resident #11 was observed self-propelling in her wheelchair repeating "what can I do?".

Review of Resident #11's activity attendance record for August 2019 indicated she participated in 1 social event, 2 games, 4 religious' events, 1 cooking activity and 4 music activities.

Review of Resident #11's activity attendance record for September 2019 indicated she participated in 2 social events, 2 games, 4 religious' events, 1 cooking activity and 1 music activity.

Review of Resident #11's activity attendance record for October 2019 indicated as of 10/24/19, she participated in 1 social event, 3 games, 3 religious events and 3 music activities. There was no documented evidence that Resident #11

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participated in the balloon stamping conducted in the dementia unit on 10/17/19 as indicated on the activity calendar.

An interview on was conducted on 10/24/19 at 11:14 AM with the AD and Assistant Activity Director (AAD). The AD stated she had been in her position for approximately one year and the AAD stated she had been in her position since last spring. The ADD stated she was responsible for activities on the dementia unit and was trained by the AD. She stated she invited residents on the dementia unit to attend activities in the main dining room but most of the time the residents were sleeping in the wheelchairs in the hallway and she did not want to wake them. She stated she did ball toss and bowling with the dementia unit residents and other things that did not appear on the activity calendar. The AAD stated she doesn't attempt any activities on the unit before 10:00 AM due to residents eating breakfast and busy with getting their activities of daily living (ADLs) completed. She further stated if she took residents from the dementia unit to activities on the main unit, she had to stay with the residents from the dementia unit and she couldn't do both. The AAD stated she did balloon toss with the residents in the dementia unit after 11:00 AM on 10/22/19 and 10/23/19. The AAD stated there was no activities in the dementia unit on weekends because on weekends, she worked as an aide. The AAD stated Resident #11 was disruptive at times in group settings and that was why she did not take her to group activities off the dementia unit. When asked if any 1:1 activity was provided for Resident #11, she stated "no".

Interview on 10/24/19 at 11:38 AM, the Administrator stated it was her expectation an

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F 679	Continued From page 41 activity be attempted with Resident #11 twice daily and that she be taken to activities per her preference and if she was disruptive, 1:1 activities of her preference should be attempted. She further stated residents on the dementia unit should have activites on the weekends.	F 679		
F 745 SS=B	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, Department of Social Services (DSS) interview, and staff interview, the facility failed to submit all required documentation for Resident #72's request for Medicaid Services application resulting in the denial of the initial application which delayed the application process for 1 of 1 residents reviewed for medically related social services. The findings included: Resident #72 was admitted to the facility on 1/22/19 with diagnoses that included orthopedic aftercare and heart failure. The quarterly Minimum Data Set (MDS) assessment dated 10/8/19 indicated Resident #72' s cognition was severely impaired. A review of Resident #72 ' s payor source for her stay at the facility indicated she converted from Medicare to private pay with Medicaid pending on 3/12/19. She remained with this same payor source until 10/1/19 when Medicaid was	F 745	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F-745 The following was accomplished for resident #72 who was affected by the practice: Resident #72 had her FL2 resubmitted on 9-4-19 by the Admissions Coordinator to	11/21/19

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approved.

A review of the request for Medicaid Services application documentation for Resident #72 indicated the initial paperwork was submitted on 3/15/19. On 3/25/19 additional information was requested from the facility and was required to be submitted within 10 business days. On 3/29/19 additional information was again requested from the facility and was required to be submitted within 10 business days. On 4/22/19 the facility was notified that the initial request for Medicaid Services application was not approved as it was missing required information. Further review indicated that on 5/21/19 additional information was requested from the facility and was required to be submitted within 10 business days. On 6/11/19 the facility received notification that the information requested on 5/21/19 was due on 6/6/19 and had not be received. On 8/7/19 additional information was once again requested from the facility and was due within 10 business days. On 8/21/19 the facility received notification that all required documentation had been received for the request for Medicaid Services application for Resident #72. This was over 5 months after the initial paperwork was submitted.

An interview was conducted with the Business Office Manager (BOM) on 10/22/19 at 10:35 AM. Resident #72 ' s payor source information from 1/22/19 through 10/1/19 was reviewed with the BOM. She reported that the former Administrator was the person responsible for submitting the request for Medicaid Services application paperwork. She revealed that this application process had not been fully completed by the former Administrator and was taken over by the Admissions Coordinator (AC) in August after the

F 745

retro back to 5-28-19 which was the month of the original request.

The following was accomplished for other residents who have the potential to be affected by the practice:

An audit was conducted by the Admissions Coordinator on November 13, 2019 of all FL2 requests in the last six months. All 15 FL2s were submitted timely.

The following system has been put in place to ensure that the practice will not recur:

The Social Worker will be responsible for ensuring that requested FL2s are submitted timely. Effective 11/14/19, the Social Worker now has access to NC Tracks. Additionally, education on the FL2 process was provided on 11/14/19 by the Admissions Coordinator and a veteran Social Worker at a "sister facility". The Social Worker will maintain a log of all FL2 requests. The log will include the resident name, the entity requesting the FL2, the date of the request, submission date and approval date.

The following monitoring initiative has been put in place to make sure that solutions are sustained:

The administrator will audit the FL2 log to ensure the timely submission of FL2s weekly for four weeks and monthly thereafter for two months or until a pattern

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F 745	Continued From page 43 former Administrator was no longer with the facility. An interview was conducted with the AC on 10/22/19 at 10:46 AM. The AC confirmed the former Administrator initiated Resident #72 ' s request for Medicaid Services application in March 2019. She also confirmed that it was not until August 2019 that the facility received notification that all required documentation had been submitted and the application was accepted. She was unable to explain why this process had not been fully completed by the former Administrator. A phone interview was conducted with Department of Social Services (DSS) staff on 10/22/19 at 4:30 PM. She confirmed that Resident #72 ' s request for Medicaid services application was delayed as a result of the facility not submitting the required paperwork by the time deadlines provided to them. DSS staff indicated that it was the former Administrator who had submitted the initial application for Resident #72 and failed to follow through with sending in the additional information that was requested. A phone interview was conducted with the former Administrator on 10/22/19 at 4:32 PM. The request for Medicaid Services application for Resident #72 was reviewed with the former Administrator. The former Administrator revealed she wasn ' t familiar with the online system utilized for paperwork submission. She further revealed that this lack of familiarity caused a delay in the submission of the required paperwork for Resident #72. An interview was conducted with the	F 745	of compliance has been established. The results of these audits will be presented to the Quality Assurance meeting monthly for review. The plan will be revised as deemed necessary.	

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F 745	Continued From page 44 Administrator on 10/24/19 at 12:01 PM. She reported that she just began working as the interim Administrator at the end of August 2019. She acknowledged that there was a delay in the request for Medicaid Services application process for Resident #72 that occurred prior to her time at the facility. She indicated that it was her expectation that application documentation be sent in within the required timeframes.	F 745		
F 947 SS=B	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure Nursing Assistants (NAs) received annual dementia management/care training. This was evident for 3 (NA #2, NA #3 &	F 947	This Plan of Correction constitutes a written allegation of compliance. Preparation and submission of this Plan of Correction does not constitute an	11/21/19

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F 947	Continued From page 45 NA #4) of 5 NAs reviewed for staffing. The findings included: NA #2 was hired by the facility on 6/5/12 as a NA. Review of NA #2's in-service training records revealed that she had not received a dementia management/care training since 10/2018. NA #4 was hired by the facility on 8/19/15 as a NA. Review of NA #4's in-service training records revealed that she had not received a dementia management/care training since 10/2018. NA #3 was hired by the facility on 5/23/18 as a NA. Review of NA #3's in-service training records revealed that she had not received a dementia management/care training since 10/2018. On 10/24/19 at 9:50 AM, the Staff Development Coordinator (SDC) was interviewed. The SDC stated that she started working at the facility as SDC in July 2019. The SDC stated that the facility provided a dementia virtual tour last June 2019 but not all employees including NA #2, NA #3 and NA #4 had attended. She added that she planned to include the dementia management/care training during orientation and then yearly. On 10/24/19 at 12:02 PM, the Administrator was interviewed. The Administrator stated that she expected all NAs received dementia management/care training at least yearly.	F 947	admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted solely because of the requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. F947 IMMEDIATE ACTION On 10/24/2019, the Staff Development Coordinator (SDC) audited education for identified nursing assistants (NAs). Nursing Assistant #2 completed dementia education on 11/11/2019. Nursing Assistant #4 completed dementia education on 11/15/2019. Nursing Assistant #3 is no longer employed with the facility. IDENTIFICATION OF OTHERS On 11/04/2019, the Director of Nursing and Staff Development Coordinator audited 100% of all nursing assistants' electronic continuing education system training compliance. Dementia education for all identified nursing assistants who were out of compliance with dementia education since 11/13/2019 has been assigned dementia education by the Staff Development Coordinator. All nursing assistants will be in compliance with dementia education on or before 11/21/2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345523	A. BUILDING ______ B. WING ______	C 10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/RAMSEUR	**7166 JORDON ROAD RAMSEUR, NC 27316**

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F 947	Continued From page 46	F 947	SYSTEMIC CHANGES Effective 11/21/2019, all assigned dementia education for nursing assistants will be tracked and monitored by the Director of Nursing/Designee and Staff Development Coordinator in the electronic continuing education system monthly for completion and compliance with assigned dementia competency. Education on dementia care will be incorporated into the facility orientation process for all newly hired nursing assistants (NAs), and will be facilitated by the Staff Development Coordinator on or before 11/21/2019. MONITORING PROCESS Effective 11/21/2019 the Director of Nursing/Designee and Staff Development Coordinator will monitor compliance by reviewing all assigned dementia education for nursing assistants in the electronic continuing education system to ensure competency and completion of assigned education. Compliance monitoring will occur weekly for 8 weeks, then bi-weekly for 4 weeks or until a pattern of compliance is maintained. The QAPI Committee can modify this plan to ensure that the facility remains in substantial compliance.	