STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345449	A. BUILDING _____ B. WING _____	C 01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/KING	115 WHITE ROAD KING, NC 27021

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E 000	Initial Comments An unannounced recertification survey was conducted on 01/14/2020 through 01/17/2020. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# FLFE11."	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 01/14/20 through 01/17/20. Event ID# FLFE11. 3 of the 12 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to provide residents access to turn on and off the overbed lighting as desired for 2 of 19 (Resident # ' s 53 and Resident #24) sampled. The findings included: 1. Resident #53 was admitted to the facility on 11/18/19 with diagnosis of, in part, right humerus fracture. An Admission Minimum Data Set assessment dated 12/6/19 revealed Resident #53 was	F 558	Universal Healthcare of King acknowledges receipt of the Statement of Deficiencies and purpose of this Plan of Correction to the extent the summary of findings is factually correct in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as written allegation of compliance. Preparation and submission of this Plan of Correction is in response to the CMS 2567 from the survey conducted on	2/10/20

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

Electronically Signed | 02/06/2020

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F 558	Continued From page 1 cognitively intact, required extensive assistance x 2 for bed mobility, extensive assistance x 1 for transfers, dressing, hygiene and bathing. She had no functional limitation in her range of motion to her left upper extremity. An observation was made of Resident #53 ' s room at 1/15/20 at 9:45 AM. The resident was observed lying in her bed with the overbed light on. The overbed light was observed with a short chain attached to turn the light on and off. The chain was too short for the resident to reach and there was no attachment enabling the resident to turn the light on and off. An interview was conducted with Resident #53 at that time. She stated she came to the facility after she fell and broke her arm. She stated she couldn ' t get out of bed on her own. The resident stated she had not had anything attached to the small chain since she was admitted and could not reach the short chain while she was in bed. She stated it would be nice to have something attached "so I can turn the light on and off. Sometimes it stays on all night and I prefer it to be off". On 1/17/20 at 9:05 AM the Maintenance Director was interviewed. He stated when a resident is discharged, he completes a room check to get it ready for the next resident. He stated that included checking the lights to make sure they have an attachment for residents to reach. Once a resident is admitted, each room is assigned an ambassador that checks on the residents and the rooms and documents on a form, but he didn ' t think the lighting attachment was included in the daily check. He stated he must have missed attaching something to the chain for this resident. On 1/17/20 at 9:15 AM the Admissions Director was interviewed. She stated they do checks	F 558	January 14-17, 2019. Universal Healthcare of King response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Furthermore, Universal Healthcare of King reserves the right to refute any deficiency on the Statement of Deficiencies through Informal Dispute Resolution, formal appeal and/or other administrative or legal procedures. F558 The alleged non-compliance occurred when the facility failed to provide residents access to turn on and off the over bed lighting as desired for Resident #53 and #24. Resident #53 and #24 were provided with access to turn on and off the over bed lighting as desired on 1/16/2020. Audit of current resident□s rooms was conducted to ensure access to turn on and off over bed lighting. This audit was completed by facility Maintenance Director on 1/16/2020. Opportunities corrected as identified. Staff educated by the Administrator on reporting maintenance concerns to ensure that resident□s needs are met. In-service completed on 2/6/2020. The Maintenance Director will audit	

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F 558	Continued From page 2 rooms after a resident discharge before a new admission arrives and each room is checked daily by a room ambassador who fills out a form once the room check is done. She stated she was the room ambassador for Resident #53. She revealed the lighting attachment wasn ' t a part of the room check but should be. 2. Resident #24 was admitted to the facility on 10/7/19 with diagnoses of, in part, nondisplaced fracture of lateral malleolus of left fibula and a history of falling. A 5 day/Admission Minimum Data Set assessment dated 10/14/19 revealed Resident #24 was cognitively intact, was non-ambulatory and required a mechanical lift for transfers. On 1/17/20 at 9:38 AM Resident #24 was interviewed. She stated she had been in the facility since October and was being discharged that day. She stated she had never had anything attached to her overbed light so she could turn it on and off. She stated "it sure would be nice" to have something there for her to reach. On 1/17/20 at 9:05 AM the Maintenance Director was interviewed. He stated when a resident is discharged, he completes a room check to get it ready for the next resident. He stated that included checking the lights to make sure they have an attachment for residents to reach. During a tour of the F hall on 1/17/20 at 9:40 AM, 2 other resident rooms did not have attachments for the overbed lighting.	F 558	resident□s rooms weekly x 12 weeks to ensure that residents have access to turn on and off the over bed lighting. Opportunities corrected as identified. The Administrator will review results of weekly audits to ensure residents have access to turn on and off the over bed lighting as desired. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Maintenance Director monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. Person/s responsible: Administrator and/or Maintenance Director	
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8)	F 561		2/10/20

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F 561	Continued From page 3 §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews and record review, the facility failed to honor a resident's choice to eat in the main dining room during the lunch meal for 1 of 3 residents (Resident #31) reviewed for choices. Findings included:	F 561	F561 The alleged non-compliance occurred when the facility failed to honor a Resident #31 choice to eat in the main dining room during a lunch meal. Resident #31 was asked where she wanted to have her meals. Resident stated she wanted to eat breakfast and supper in her room and	

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F 561	Continued From page 4 Resident #31 was admitted to the facility on 11/10/11. Cumulative diagnoses included, in part, congestive heart failure and diabetes. The quarterly Minimum Data Set assessment dated 11/15/19 revealed Resident #31 was cognitively intact. The resident's meal tray card was provided by the Dietary Manager on 1/16/20 at 1:30 PM and it indicated Resident #31's preferred location for the lunch meal was the main dining room. The facility's daily nursing staffing assignment sheets from 12/14/19-1/15/20 were reviewed. The assignment sheets indicated on 12/15/19- meals were served on the halls, 12/24/19- lunch and supper was served on the halls, 12/26/19- meals were served on the halls, 12/29/19- meals were served on the halls, 1/10/20- "eat on halls," and 1/11/20- "eat on halls." On 1/14/20 at 12:43 PM an interview was completed with Resident #31 while she ate lunch in her room. She stated the dining room was closed "a lot" and she thought it was because there was not enough staff. She said staff notified residents if meals were not served in the dining room but they typically gave no reason as to why the dining room was not opened for meals. Resident #31 reported residents were unable to eat in the dining room on 1/13/20 and further stated that often on Saturdays and Sundays the residents ate in their rooms instead of the dining room. Resident #31 revealed she preferred to eat lunch in the dining room and sometimes wanted to eat supper in the dining room. She recalled the dining room was nicely decorated at Christmas but there were days when residents	F 561	occasionally lunch in the Main Dining Room. Resident #31□s tray card already reflected this preference. An audit was performed by the Director of Nursing on all residents and their preference of where they want to eat their meals. All resident□s tray cards were updated to reflect the resident□s wishes and preferences. Audit completed on 2/4/2020. Nursing staff was educated by Director of Nursing on the numeric system that indicates the location where the resident wishes to eat meals. Education completed on 2/6/2020. Social Services was educated by Administrator to notify the Resident Council and/or Resident Council President if a dining venue will be used for other purposes. Education completed on 2/6/2020. Dietary Manager will interview 10 residents per week to ensure that the residents dining preferences are met. The interviews will continue for 4 weeks and then monthly for 3 months. Administrator will review the results of the interviews to ensure that the residents dining preferences are met. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Dietary Manager monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is	

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F 561	Continued From page 5 were unable to eat in the dining room. Resident #31 said she told the Activities Director, "It was a shame that we couldn't eat in the dining room; we wanted to take it all in and yet couldn't eat in the dining room." She further stated she was told by some of the nurse aides there wasn't enough staff for meals to be served in both the dining room and on the halls. Resident #31 explained that she enjoyed eating in the dining room because she liked to socialize with other residents. On 1/14/20 at 1:02 PM an interview was completed with Nurse Aide (NA) #1 who indicated the dining room was closed and stated, "We haven't eaten in the dining room all week because we are short of staff." NA #2 was interviewed on 1/16/20 at 10:10 AM. She explained that the dining room was open for three meals per day and typically staff asked residents if they wanted to go to the dining room for meals. She said the only time the dining room was not open was when there was not enough staff and gave an example if there was only one staff member on a hall then there wasn't anyone available for meals to be served in the dining room. NA #2 revealed staff were notified if the dining room was closed when they looked at the schedule book or it was announced over the facility intercom system. She recalled that "a few weeks ago it happened quite often." An interview on 1/16/20 at 1:29 PM with the Dietary Manager revealed that according to Resident #31's preferences and tray card, she preferred to eat lunch in the dining room and ate breakfast and supper in her room.	F 561	necessary to maintain compliance. Person Responsible: Administrator and/or Dietary Manager	

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F 561	Continued From page 6 On 1/16/20 at 2:09 PM an interview with the Activities Director revealed there were times the facility was short of staff and meals were served on the halls because there was not enough staff for meals to be served in the dining room. She recalled during Christmas there were some changes with staffing, less staff were available and meals were served on the halls. The Activities Director said she thought Resident #31 might have told her she didn't like that she had to eat all meals in her room and that she preferred the dining room. She recalled the residents enjoyed the atmosphere of the dining room at Christmas. On 1/17/20 at 12:48 PM an observation was made of Resident #31 as she ate lunch in the dining room. Resident #31 said she was happy to be in the dining room for the lunch meal. The Director of Nursing (DON) was interviewed on 1/17/20 at 3:03 PM. She reported when census and staffing numbers were down on the night shift there wasn't enough staff available who assisted residents out of bed in time for breakfast and meals were served on the halls so the food wouldn't get cold. During the interview the daily nursing staff assignments sheets were reviewed with the DON and she indicated there was plenty of staff available and was unsure why notes were written on the assignment sheets to serve some meals only on the halls. She said typically someone was assigned to cover the dining room and someone was assigned to cover the halls for meal times.	F 561		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		2/10/20

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F 641	Continued From page 7 §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 and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of medications for 2 of 5 residents (Resident # ' s 39 and 53) reviewed for unnecessary medications. The findings included: 1. Resident #39 was admitted to the facility on 3/20/19 with diagnosis of atrial fibrillation. A review of the physician ' s orders for November 2019 revealed an active order for Eliquis (an anticoagulant medication) 5 milligrams via peg tube twice a day ordered on 4/20/19. A review of the November 2019 Medication Administration Record revealed Resident #39 received Eliquis from 11/15/19 - 11/21/19, the MDS assessments 7 day look back period. A review of a quarterly MDS dated 11/21/19 under section N (Medications) revealed no documentation the resident received an anticoagulant during the look back period. An interview was conducted with MDS Nurse #1 on 1/17/20 at approximately 10:30 AM. She stated according to the manual, Eliquis isn ' t coded on the MDS. She stated only the "heavy hitters" are coded. 2. Resident #53 was admitted to the facility on 11/18/19 with a diagnosis of history of embolism	F 641	F641 The alleged non-compliance occurred when the facility failed to accurately code the Minimum Data Set assessment in the areas of medications for residents #39 & #53 reviewed for unnecessary medications. The MDS Coordinator modified the assessment for resident #39 and #53 to reflect the correct coding on 1/15/2020. Section N, of the Minimum Data Set (MDS), for all current residents, will be audited for the last 30 days to ensure coding accuracy by the MDS Coordinator. Opportunities will be corrected by the MDS Coordinator and submitted. MDS staff will be re-educated by the Regional Clinical Reimbursement Consultant on the importance of accurately coding the MDS, specifically medications on 02/05/2020. The DON will audit Section N by comparing the medication administration record during the assessment reference date with the coding information under Section N of 5 MDSs per week x 4 weeks and monthly for 3 months to ensure accuracy. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the MDS Staff	

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F 641	Continued From page 8 and thrombosis of left popliteal vein. A review of the December 2019 physician ' s orders revealed an order for Xarelto (an anticoagulant) 15 milligrams by mouth twice a day for 21 days. A review of the Medication Administration Records for November 2019 and December 2019 revealed Resident #53 received Xarelto 15 milligrams twice daily on 11/30/19 and 12/1/19 - 12/6/19, the MDS assessments 7 day look back period. A review of an admission MDS dated 12/6/19 under section N (Medications) revealed no documentation of Resident #53 receiving an anticoagulant medication. An interview was conducted with MDS Nurse #1 on 1/17/20 at approximately 10:30 AM. She stated according to the manual, Xarelto isn ' t coded on the MDS. She stated only the "heavy hitters" are coded.	F 641	monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. Person Responsible: DON and/or MDS Staff	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission.	F 655		2/10/20

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F 655	Continued From page 9 (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to develop a baseline care plan that included individualized information to provide effective, person-centered care for a resident using a CPAP (continuous positive airway pressure) and a resident using a sling	F 655	F655 The alleged non-compliance occurred when the facility failed to develop a baseline care plan that included individualized information to provide effective, person-centered care for a	

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F 655	Continued From page 10 after an arm fracture for 2 of 9 new admissions (Resident #77 and Resident #53). The findings included: Resident #77 was admitted to the facility on 12/26/19 with diagnoses of, in part, obstructive sleep apnea and Alzheimer ' s. A 5day/Admission Minimum Data Set assessment dated 1/2/20 revealed Resident #77 had severely impaired cognition. He required extensive to total dependence on staff for his activities of daily living. The assessment indicated Resident #77 utilized a CPAP machine while he was a resident. A record review revealed an active physician ' s order dated 12/26/19 to "encourage use of CPAP at bedtime". A review of the Medication Administration Record for December 27th, 2019 - January 2, 2020 (the MDS look back period), revealed the CPAP was documented as administered for 12/27, 12/28, 12/29, 12/30, 12/31 and 1/1. A record review revealed a Baseline Care Plan dated 12/26/19. The Special Treatments/Procedures section that would include use of a CPAP was left blank for Resident #77. The CPAP machine usage was not added to the comprehensive care plan until 1/15/20. On 1/17/20 at approximately 10:30 AM, MDS Nurse #1 was interviewed. She stated she would have to look into why Resident #77 ' s CPAP wasn ' t included on the baseline care plan. She returned at approximately 11:30 AM and stated	F 655	resident using a CPAP (Resident # 77) and a resident using a sling after an arm fracture (Resident #53). Baseline care plans for Resident #77 was updated on 1/15/2020 and #53 were updated on 1/16/2020 to reflect the use of these items. An audit of baseline care plans for admissions in the last 30 days was conducted by the MDS Coordinator to ensure that the baseline care plans included individualized information to provide effective, person-centered care on 01/17/2020. The IDT team was educated by the Regional Clinical Reimbursement Consultant on developing the baseline care plan to include individualized information to provide effective, person-centered care on 02/05/2020. Baseline care plans for new admissions will be audited by the MDS. This audit will occur weekly x 4 weeks then monthly for 3 months to ensure they include individualized information to provide effective, person-centered care. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the MDS monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. Person Responsible: Administrator	

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F 655	Continued From page 11	F 655		

Resident #77 ' s wife removed the CPAP machine last night. She could not answer why the CPAP machine did not get included on the baseline care plan.

2. Resident #53 was admitted to the facility on 11/18/19 with diagnoses of right humerus fracture.

A review of the Admission Minimum Data Set assessment dated 12/6/19 revealed Resident #53 required extensive assistance x 2 people for bed mobility and extensive assistance x 1 for transfers, dressing, toileting, hygiene and bathing. Resident #53 had poor balance and had limitation in range of motion of her upper extremity. Resident #53 was frequently incontinent of bladder and continent of bowel.

A review of an orthopedic consult note dated 11/14/19 revealed Resident #53 was seen for follow up for right humerus fracture. The instructions included: continue sling and remain non-weight bearing.

A review of the Baseline Care Plan dated 11/18/19 for Resident #53 did not include use of a sling to her right arm or her non-weight bearing status.

An observation on 1/14/20 at 11:37 AM of Resident #53 revealed resident out of bed to her wheelchair eating lunch. A blue sling was observed on the couch in the residents ' room. Resident #53 stated she had a shower that morning and they hadn ' t put the sling back on.

A review of an orthopedic consult note dated 1/14/20 revealed Resident #53 was seen for 8

and/or MDS Staff

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F 655	Continued From page 12 weeks post injury of right shoulder. Included in the plan read, "sling for protection/reminder". On 1/17/20 at approximately 10:30 AM, MDS Nurse #1 was interviewed. She stated she would have to look into why Resident #53 ' s sling wasn ' t included on the baseline care plan. On 1/17/20 at approximately 11:30 AM, the Director of Nursing stated that Resident #53 was in and out of the hospital and the sling for Resident #53 wasn ' t ordered.	F 655		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews, the facility failed to apply an arm sling to a resident with a healing	F 688	F688 The alleged non-compliance occurred when the facility failed to provide an arm	2/10/20

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F 688	Continued From page 13 humerus fracture for 1 of 3 residents (Resident #53) reviewed for range of motion. The findings included: Resident #53 was admitted to the facility on 11/18/19 with a diagnosis of right humerus fracture. A review of an orthopedic consult report dated 11/14/19, prior to Resident #53 being admitted to the facility, revealed: continue sling, range of motion to right elbow, wrist and fingers and remain non-weight bearing. A review of an Admission Minimum Data Set assessment dated 12/6/19 revealed Resident #53 required extensive assistance x 2 with bed mobility and extensive assistance x 1 for transfers, dressing, toileting, bathing and hygiene. She had poor balance and had a functional limitation in range of motion to her right upper extremity. A review of the care plan dated 12/6/19 revealed a problem for risk for complications related to right humerus fracture. Goal: resident ' s fracture will heal without complications through next review. An intervention was sling to right upper extremity as ordered. An observation on 1/14/20 at 11:37 am revealed Resident #53 out of bed to her wheelchair eating lunch. The surveyor introduced herself and explained why she was there. A blue sling was observed on the couch in the room. The resident stated she had a shower earlier that morning and the sling wasn ' t put back on. A review of an orthopedic consult report dated	F 688	sling for a healing humerus fracture (Resident #53). Arm sling was applied while up in wheelchair on 1/15/2020. Resident continues on rehab caseload. Occupational Therapy will re-assess all residents with current orders for orthopedic devices to determine the need for continued use of orthopedic devices. The Rehab Manager will coordinate these assessments and report the findings to the Administrator by 02/10/2020. Licensed and certified nursing staff will be re-educated by the Director of Nursing and/or Rehab Manager on the proper donning and doffing of orthopedic devices by 02/10/2020. Nurse managers will monitor 5 residents with orthopedic devices to ensure they are in place 1 x per week x 4 weeks, and then monthly for 3 months. Opportunities corrected as identified. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. Person Responsible: Administrator and/or Director of Nursing	

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F 688	Continued From page 14	F 688		

1/14/20 revealed Resident #53 was seen for post right shoulder injury. The report indicated the resident ' s pain was improving. The report read: Plan: sling for protection/reminder.

An observation on 1/15/20 at 1:30 PM revealed Resident #53 in her room out of bed to her wheelchair. The resident asked the surveyor who she was, and the surveyor reminded her. There was no sling in place to her right upper extremity.

An observation on 1/16/20 at 11:19 AM revealed Resident #53 in her room out of bed to her wheelchair. She again asked the surveyor who she was, and again the surveyor reminded her. There was no sling in place to her right upper extremity.

An interview was conducted with the Rehabilitation Director on 1/16/20 at 1:16 PM. She revealed Resident #53 did have confusion and was forgetful. She stated the resident saw the orthopedist on 1/14/20 and weight bearing status had increased but still limited at 10 pounds. She stated she was fine with the resident not wearing the sling while she was in bed and while therapy was working with her, but the nursing staff needed to apply it when she was out of bed in her wheelchair to protect the arm and remind her not to lift things because she was forgetful.

An interview was conducted with NA #3 on 1/16/20 at 2:20 PM. NA #3 was aware that Resident #53 used a sling to her right arm. She stated the information was located on the residents Kardex and she looked at it every day. When NA #3 was asked why the resident had not been wearing it, NA #3 replied therapy was

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F 688	Continued From page 15 applying it. An interview was conducted with the Director of Nursing (DON) on 1/17/20 at approximately 11:30 AM. She stated the sling for Resident #53 was not ordered and only used for reminders. The surveyor informed the DON the orthopedist also noted the sling to be worn for protection. The DON stated no one was monitoring the use of the sling because it was not ordered. On 1/17/20 at 1:42 PM, an observation of Resident #53 in her room revealed she was out of bed to her wheelchair and did not have a sling in place. There was no sling visible in the room. An interview with NA #4 at that time revealed she knew she had a sling. The surveyor asked NA #4 when the resident was supposed to wear it and she responded, "I can go find out".	F 688		
F 825 SS=D	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized	F 825		2/10/20

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F 825	Continued From page 16 rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review, the facility failed to provide rehabilitative services to improve mobility after a resident won an appeal from termination of therapy services for 1 of 1 resident (Resident #26) reviewed for rehabilitative services. Findings included: Resident #26 was admitted to the facility on 11/1/19 with diagnoses that included, in part, diabetes and hypertensive heart disease. The admission Minimum Data Set assessment dated 11/8/19 revealed Resident #26 was cognitively intact, started occupational therapy (OT) on 11/2/19 and physical therapy (PT) on 11/4/19. A care plan problem was developed for activities of daily living (ADLs) with a goal of, "Resident will participate in rehab to regain strength and abilities to perform and maintain ADLs at prior level of function." A care plan approach included, "Therapy screen as needed." The medical record revealed Resident #26 was her own responsible party. A physician order dated 11/2/19 stated, "OT to follow for 40 times in eight weeks to include therapeutic activities, therapeutic exercises, neuromuscular re-education, self care and group	F 825	F-825 The alleged non-compliance occurred when the facility failed to providing Specialized Rehab services for resident #26 during an Appeal process. The Rehab Director and Rehab team was in-serviced as to providing specialized rehab services for the entire time period during an Appeal. The in-service was conducted by the Facility Administrator. The in-service was completed on 2-6-2020. Resident #26 was referred and carried on Restorative Nursing services on 1/16 through 1/21. Resident self-terminated restorative nursing services as of 1/21/2020. Resident #26 was screened on 2/10/2020 by rehab services to determine most appropriate transfer. An Audit was performed on any other individuals that have filed an Appeal in the last 3 months. All discharge appeals are to be reported to the Facility Administrator/DON for review. Therapy discharges will be monitored on a case by case basis and documented by the Therapy department. The Administrator will monitor all Appeals for 4 weeks and then monthly for 2 months until substantial compliance is maintained. This will be reported to the QA Committee monthly for recommendations or modifications until a pattern of compliance is achieved.	

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therapy."

A physician order dated 11/4/19 revealed, "Resident will receive skilled PT services 60 times in twelve weeks to address gait difficulty and muscle weakness. Treatment will focus on neuromuscular re-education, therapeutic exercises, therapeutic activities, group therapy, gait training, orthotic management and training."

A physician order effective 11/20/19 indicated, "Patient is discharged from skilled PT services as no further progress can be expected with continued skilled PT intervention."

A physician order dated 11/21/19 revealed, "Discharge from OT due to maximum rehabilitation potential."

The PT Discharge Summary reported a start of care date of 11/4/19 and end of care date of 11/20/19. The discharge summary indicated Resident #26 was, "discharged from skilled PT services due to a change in the patient's payer source."

A CMS-10123 Notice of Medicare Non-Coverage letter (NOMNC) was signed by Resident #26 on 11/19/19. The notice indicated that Medicare coverage for skilled services was to end 11/21/19. Resident #26 appealed the decision to end Medicare coverage for skilled services.

An electronic mail communication sent from the Denials Coordinator (who received the appeal decision from the insurance company) to the facility on 11/23/19 stated, " ...The member won their health plan appeal. The member has been approved for continued stay with a next review

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date of 11/29/19. Please fax in updates on that date."

Resident #26's medical record showed no further therapy notes or evidence that the resident received therapy services after she won her appeal on 11/23/19.

Interviews were completed with Resident #26 on 1/14/20 at 2:55 PM and on 1/16/20 at 2:49 PM. During the interviews the resident recalled when she first came to the facility she received therapy for about 2-3 weeks and then was told by the therapist that the therapy was going to be discontinued. Resident #26 said she appealed the decision that "they had dropped me from therapy."

On 1/16/20 at 8:35 AM an interview was completed with the Social Worker (SW) and Rehabilitation (Rehab) Director. They confirmed Resident #26 was her own responsible party. The Rehab Director said originally the last covered day (LCD) of skilled services was 11/21/19 since the resident was uncooperative with the therapist and had "plateaued" in her treatment. A NOMNC was reviewed with Resident #26, she appealed the decision and "we went through the appeals process." After the appeal was submitted and reviewed, the insurance company notified the facility on 11/23/19 that the resident won her appeal and services were re-authorized through 11/29/19. The Rehab Director stated after Resident #26 won the appeal the therapy department had not resumed therapy services for the resident. She explained, "From an OT/PT standpoint we felt she was no longer appropriate for therapy. She was at a maintenance level and had plateaued."

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F 825	Continued From page 19 She further confirmed from 11/23/19-11/29/19 Resident #26 received no therapy services and stated, "She was no longer appropriate for therapy." The SW added another NOMNC was reviewed with Resident #26 on 11/26/19 with a LCD of 11/29/19 and the resident appealed again but the discharge from skilled services was upheld by the insurance company. A follow up interview was completed with the Rehab Director on 1/16/20 at 2:29 PM. She said that typically when a resident won an appeal the Rehab department continued with therapy services and admitted, "The fact that she did not receive therapy after she won the appeal is on me. I saw no clinical reason for her to continue rehab. We just re-sent the discharge summaries on the second appeal." During an interview with the Administrator on 1/16/20 at 5:03 PM he expressed if the facility had given therapy after Resident #26 won her appeal "it would be against the professional clinical opinion."	F 825		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on an observation during the initial tour of the kitchen, records and staff interviews, the facility failed to maintain foods in a safe environment. There was a large hole in the floor of 1 of 1 walk-in cooler.	F 921	F921 The alleged non-compliance occurred when the facility failed to repair a hole in the walk-in cooler in the facility□'s kitchen. The hole in the walk-in cooler was	2/10/20

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F 921	Continued From page 20 Findings included: During the initial tour of the kitchen with the DM (Dietary Manager) on 01/14/20 at 10:05 a.m. dietary staff were observed receiving and storing food supplies in the walk-in cooler. The internal temperature of the walk-in cooler was 41 degrees Fahrenheit. There were no visible signs of debris or infestation, but approximately two feet from the entrance into the walk-in cooler there was a large, jagged hole through the aluminum floor and through part of the cement beneath the floor in front of the storage racks. Upon request, the DM measured the hole in the floor as 9-inches in width, 19-inches in length, and with a depth of 1 ¾ inches. During an interview on 01/14/20 at 10:42 a.m., the DM revealed the floor in the walk-in cooler had been in disrepair for approximately 3-4 years. She stated that the facility's Maintenance Director had assessed the hole, obtained quotes from outside contractors and submitted the quotes to the corporate office. The DM indicated the facility was awaiting a response from the corporate office. Review of the construction estimate dated 12/27/19 revealed the facility obtained a quote for the extraction and replacement of the aluminum diamond plated flooring in the walk-in cooler/freezer. During an observation with the DM on 01/16/20 at 12:15 p.m., the hole in the floor of the walk-in cooler had been covered with a cement type material. The DM revealed the Maintenance	F 921	repaired on 1/28/2020. An Audit was performed throughout other areas of the facility by the Maintenance Director to identify other areas of concern 01/16/2020. Opportunities corrected as identified. The Maintenance staff and the Facility department heads were educated by the Plant Operations Director as to reporting areas of concern that would affect the Safety/Functional/Sanitary/ or Comfortable environment. Education provided on 1/23/2020. The Maintenance Director will monitor for areas of concern during weekly rounds and report findings to the Administrator. The Administrator will review the Maintenance Director□s weekly rounds report weekly x 4 weeks and then 3 months to ensure any areas of concern are corrected. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Maintenance Director monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. Administrator and/or Maintenance Director will be responsible.	

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Director applied the cement sealant to the hole in the floor on 1/14/20, after the initial tour.

During an interview on 01/17/20 at 8:44 a.m., the Maintenance Director stated that approximately one year ago the DM notified him of the hole in the floor of the walk-in cooler. He indicated he assessed the hole as approximately 2 inches in diameter. He stated he collected quotes from three contractors (twice because the quotes expired after thirty days) and submitted the quotes to the previous Administrator who was to obtain a CER (capital expense request) from the facility's corporate office. He stated that as follow-up he spoke with the previous Administrator concerning the submitted quotes and was informed the corporate office had not approved the CER.

During an interview on 01/17/20 at 8:44 a.m., the Maintenance Director stated that in December 2019, he spoke with the present Administrator about the hole in walk-in cooler and was directed to obtain a quote from a contractor. The quote was obtained and submitted for CER on 12/27/19 to the facility's corporate office. He revealed the facility's corporate office approved the replacement of the floor in the walk-in cooler on 1/14/20. He indicated that he re-assessed the the hole in the floor of the walk-in cooler on 1/14/20 and the measurement from the most center point of the hole was 3-inches wide and 8-inches long. He stated that until the floor of the walk-in cooler was replaced, hydraulic cement was temporarily placed in the hole until the floor could be replaced. This was not done before because he had not realized the hole had expanded in length and depth during this period.

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F 921	Continued From page 22 01/17/20 at 4:20 p.m., the Administrator revealed he was made aware of the hole in the floor of the walk-in cool several months ago but did not observe it until 1/14/20. He stated that he was unaware of any prior quotes collected for the replacement of the floor in the walk-in cooler. He indicated when the Maintenance Director informed him about the hole in the floor of the walk-in cooler in December 2019, a quote for replacement of the floor was obtained on and submitted to the facility's corporate office on 12/27/19.	F 921		