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	345130	A. BUILDING _____ B. WING _____	C 02/28/2020

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CURIS AT CONCORD NURSING & REHABILITATION CENTER	515 LAKE CONCORD ROAD NE CONCORD, NC 28025

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E 036 SS=F	EP Training and Testing CFR(s): 483.73(d) *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this	E 036		3/23/20

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

Electronically Signed | 03/23/2020

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E 036	Continued From page 1 section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop and maintain an annual emergency preparedness training and testing program for the facility's staff. Findings included: The facility's emergency preparedness (EP) manual was reviewed on 2/26/2020. The EP manual did not include any information about the training or testing of the facility's emergency preparedness plan during 2019 and 2020. On 2/28/2020 at 1:32 pm the Maintenance Director stated he was responsible for training and testing staff for Emergency Preparedness. He stated they had an Emergency Preparedness tabletop discussion with the department	E 036	This Plan of Correction constitutes the facilities allegation of compliance for the deficiencies citied in the CMA-2567 . The statement made in the plan of Corrections are not admission to and do not indicate an agreement with alleged deficiencies. This Plan of Correction is written and executed as to remain in compliance with all Federal and State regulations such that all alleged deficiencies cited have been or will be corrected by the date (s) indicated. Response to this statement of Delicense does not constitute an admission that any deficiency is accurate. No residents were named in the citation On 2-27 20 the Administrator completed an annual Emergency Management	

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E 036	Continued From page 2 managers before the previous Administrator left the facility. The Maintenance Director was not able to provide information regarding what was discussed or who was present at the emergency preparedness discussion. The Maintenance Director stated the previous Administrator kept the information regarding the Emergency Preparedness tabletop discussion in his office and neither him or the new Administrator had been able to find the information. During an interview with the Administrator on 2/28/2020 at 2:42 pm she stated the facility should have provided training and testing of the emergency preparedness plan. The Administrator stated she had been at the facility since December 2019. She stated since she became the facility's administrator there had been no training or testing of the facility's EP plan, but they planned to have an Emergency Preparedness Drill this week.	E 036	Preparedness training program with administrative staff. On 3-5-2020 administrator in-serviced other facility staff on the facility Emergency Management Preparedness training program. The facility emergency preparedness training program will be reviewed and approved by the Facility Safety Committee and reviewed annually with committee. Administrator will update changes to the emergency preparedness plan as they change throughout the year. Any changes will be reviewed in the monthly Facility Safety Committee meeting. The safety committee consists of the Administrator, Director of Nursing, Maintenance Directory, Staff development Coordinator, Unit Managers, Dietary Manager, Administrative and line staff from other departments. Updated Emergency Preparedness Plan will be reviewed with Quality Assurance Process Improvement Committee and any updates will be reviewed /approved by the QAPI Committee as they arise.	
F 000	INITIAL COMMENTS A recertification survey and complaint investigation was conducted 2/23/2020 to 2/28/2020. Immedicate Jeorpardy was identified at CFR 483.45 at tag F757 at a scope and severity J. The tag F757 constituted Substandard Quality of Care. Immediate Jeopardy began on 2/10/2020 and was removed on 2/28/2020. An extended survey was conducted. 5 allegations	F 000		

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F 000	Continued From page 3 were investigated, 1 allegation was substantiated.	F 000		
F 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically	F 580		3/23/20

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F 580	Continued From page 4 update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, observations, staff, and physician interviews, the facility failed to seek clarification and obtain orders regarding the use of a cardiac monitor which was on the resident when he was admitted from the hospital (Resident #77) for one of three residents sampled for notification. The findings included: Review of Resident #77 ' s hospital discharge summary, dated 12/11/19, revealed no information regarding a cardiac monitor for Resident #77 upon discharge from the hospital. Resident #77 was admitted to the facility on 12/11/19. The resident ' s cumulative diagnoses included: Stroke, diabetes, a blood clot in the heart, cognitive communication deficit, dementia, and adjustment disorder. Review of Resident #77 ' s admission orders for the facility, dated 12/11/19, revealed no physician ' s orders regarding a cardiac monitor.	F 580	This Plan of Correction constitutes the facilities allegation of compliance for the deficiencies citied in the CMA-2567 . The statement made in the plan of Corrections are not admission to and do not indicate an agreement with alleged deficiencies. This Plan of Correction is written and executed as to remain in compliance with all Federal and State regulations such that all alleged deficiencies cited have been or will be corrected by the date (s) indicated. Response to this statement of Delicense does not constitute an admission that any deficiency is accurate. Resident #77 no longer at facility. The facility contacted the cardiac monitor providing company, who was monitoring the device . The providing company informed the facility that the company notifies the prescribing physicians office of monitoring results. (i.e.: compliance or non-compliance). The facility was also	

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F 580	Continued From page 5 An admission note for Resident #77, dated 12/11/19 and timed 6:28 PM, by Nurse #2 documented the resident had a cardiac monitor in place that was put into place prior to discharge from the hospital and the resident was to continue to wear the monitor for 30 days. Further review revealed the nurse documented the resident had a scheduled follow up cardiac visit (no date, nor time, was documented in the note). The Treatment Administration Record (TAR) for Resident #77 for the months of December, January, and February were reviewed and no information regarding the use of a cardiac monitor was discovered. The Medication Administration Record (MAR) for Resident #77 for the month of December, January, and February was reviewed and there was an order dated 12/19/19 regarding changing the wire leads to the cardiac monitor every three days and were signed off on 12/19/19, 12/22/19, 12/25/19, 12/28/19, 12/31/19, 1/3/20, 1/6/20, 1/9/20, 1/12/20, 1/15/20, 1/18/20, 1/21/20, 1/24/20, 1/27/20, 1/30/20, 2/2/20, 2/8/20, 2/11/20, 2/14/20, and 2/20/20. The resident was documented as having had a note to see nurses ' notes regarding 2/5/20, 2/17/20, and 2/23/20. Review of Resident #77 ' s comprehensive admission Minimum Data Set assessment with a reference date of 12/13/19 revealed the resident was coded as not having cognitive loss and requiring extensive assistance of one, two, or more people for bed mobility, dressing, toilet use, and was totally dependent for bathing. During an observation conducted in conjunction	F 580	informed that if any changes were to be made regarding the cardiac monitor the company would contact the facility and when someone is not using the device it is to be retuned to the monitor company. This information was communicated to resident #77's responsible party by the company and the responsible party retrieved the monitoring device and returned to the company . The cardiac monitor belonging to resident #77 was not in use and was given to Responsible Party so that cardiac monitor can be returned to the manufacturer on 2/25/20. The facility had no contact information for the provider. Unit manger spoke with power of attorney for resident #77 who provided contact information regarding the company that provide the cardiac monitor . The cardiac monitoring company informed the unit manager that the device was for monitoring purposes only and was returned . All residents requiring cardiac monitoring devices have the potential to be affected. If a resident is admitted to facility wearing a device (i.e.:cardiac monitor)and no orders or information about the device is included in the admission paper work the admitting nurse is to contact the facility resident was admitted from and request information related to the device , such as duration , reason for monitoring , and if follow up is needed. There are no residents requiring the use of a cardiac monitoring device. All licensed nursing staff will be educated on receiving proper	

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with an interview with Resident #77, on 2/23/20 at 11:03 AM, a cardiac monitor was observed on the floor to the left of the resident ' s bed and was plugged into a charger. There was a display screen which had a visual picture of a human chest and a message was displayed to hook the electrodes up. The cardiac monitor was not observed to have been hooked up to the resident. Due to the resident ' s confusion, the resident was unable to provide an answer as to what the device was and if he should have been wearing it.

During an observation conducted of Resident #77, on 2/24/20 at 11:52 AM, a cardiac monitor was observed on the resident ' s bedside table to the left of the resident ' s bed and was plugged into a charger. There was a display screen which had a visual picture of a human chest and a message was displayed to hook the electrodes up. The cardiac monitor was not observed to have been hooked up to the resident.

During an interview with NA #1 on 2/24/20 at 1:24 PM she stated she was assigned to Resident #77 and he was supposed to wear a cardiac monitor, but he was non-compliant and would take it off.

An interview was conducted on 2/24/20 at 1:50 PM with Nurse #3 who stated Resident #77 was on her assignment. She stated the resident did have a cardiac monitor but the resident ' s Power of Attorney (POA) had come to the facility that day and she had told the POA to take the cardiac monitor. The nurse stated she had not received any phone calls from a cardiologist asking as to where the cardiac monitor was. The nurse stated her assumption was the resident was non-compliant with the cardiac monitor. The nurse stated the resident arrived to the facility

care and follow up orders for any cardiac monitor device that a resident may be admitted into the facility with on 3/22/2020.

The Director of Nursing Services, or designee, will audit all potentially affected residents upon admission 5 times a week x 4 weeks, then 3 times a week x 4, then weekly x 1 month or until corrective action is achieved.

Findings will be reviewed with the administrator weekly. Results will be discussed and addressed as needed during the facility□s monthly Quality Assessment and Performance Improvement (QAPI) meeting.

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with the cardiac monitor and the admission orders was the resident was to wear the monitor for 30 days.

An interview was conducted on 2/25/20 at 3:08 PM with the Medical Records Director. She stated she was trying to track down the cardiologist who ordered the cardiac monitor for Resident #77.

An interview with Nurse #2 was conducted in conjunction with an observation on 2/25/20 at 3:58 PM. She stated when Resident #77 was admitted from the hospital on 12/11/20, he had the cardiac monitor in place. The nurse said the monitor was put into place at the hospital prior to his discharge from the hospital. The nurse remembered the resident was very non-compliant with the cardiac monitor such as pulling the wire leads off and putting the cardiac monitor into the drawer. The nurse stated she remembered the resident was supposed to wear the monitor for 30 days but was unable to discover the order when she reviewed the resident ' s medical record. The nurse stated there was no order regarding the resident wearing the cardiac monitor or how long he should have worn the cardiac monitor. She stated when she had received report from the nurse at the hospital it was reported to her the resident was to wear the cardiac monitor for 30 days. The nurse stated he had the cardiac monitor on him when he was admitted but it was not documented on the admission assessment. The nurse stated the daughter had came to the facility and picked up the monitor and was going to send it back. Upon observation of the room, the cardiac monitor was not in the room, but a box which the cardiac monitor was to be placed in and mailed in was still in the resident ' s wardrobe

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closet.

During a phone interview conducted on2/27/20 at 2:56 PM with the receptionist at the neurology department at the hospital the resident was discharged from she stated the Family Nurse Practitioner had ordered the cardiac monitor due to Resident #77 having had heart palpitations during his hospital stay.

A phone interview was conducted, on 2/27/20 at 3:44 PM, with the Family Nurse Practitioner (FNP) who had ordered the cardiac monitor prior to Resident #77 ' s discharge from the hospital. The FNP stated the cardiac monitor had been ordered because the resident had experienced some abnormal cardiac rhythms during his hospitalization. She said upon review of the information from the cardiac monitor there were 3 occurrences where the monitor had picked up abnormal cardiac rhythms which concerned her, although they were not serious enough to trigger the monitoring company to have sent her an alert. The FNP said she had not received communication from the facility regarding the resident ' s use of the cardiac monitor nor was there any documentation in his record of the facility trying to contact someone at the hospital regarding the monitor. The FNP further explained it would have been beneficial for her to have had more cardiac readings due to the resident ' s history of cardiac abnormalities. She stated she would have liked to have been contacted regarding the resident ' s non-compliance with the cardiac monitor. She explained the cardiac monitor was supposed to be worn for 30 days and upon completion of the 30 days, the cardiac monitor was to be placed in a previously addressed box and sent back to the company

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who supplied the monitor. The FNP stated she did not understand how come the cardiac monitor had not been sent back after the 30-day period. The FNP additionally stated the facility could have contacted the number on the box or on the information in the box if they had questions as to what to do with the monitor in addition to trying to contact her or the hospital.

Resident #77 ' s Nurse Practitioner (NP) was interviewed on 2/26/20 at 8:37 AM and he stated he was aware the resident was admitted with a cardiac monitor in place and was aware the resident was non-compliant with the monitor. The NP stated he was unaware as to the reason the monitor was put into place and there was no information in the discharge summary from the hospital regarding the monitor. The NP stated he had not attempted to contact the hospital regarding how come the monitor was put into place or parameters regarding the use of the monitor and he was not aware if any of the nurses had attempted to gain clarification regarding the monitor from the hospital. The NP said he was not aware if there was an order for the use of the monitor. The NP further stated there were several kinds of cardiac monitors, and the length of their use could vary and he did not know what kind the resident had and he did not know if he had a follow up with a cardiologist regarding the monitor and would have to go back and look through the whole chart to have a clear picture of what the entire chart said. The NP stated he did not know if the cardiac monitor would go on the MAR or where it would have been documented in the medical record. He said the nurses had told him the resident was non-compliant with the monitor. The NP further stated it would have been a normal practice to

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follow up with the hospital to find out why the cardiac monitor had been placed, if there was cardiologist for the monitor, and what the plan was for the cardiac monitor.

The resident ' s physician was interviewed on 2/28/20 at 11:26 AM he stated the NP was at the facility 5 days per week and if there were questions regarding the cardiac monitor for Resident #77, he would have expected the nurses to have followed up with the NP. The physician further explained eventually he would expect for the resident to have followed up with a cardiologist regarding what the results were from the cardiac monitor. The physician stated if a resident arrived with a cardiac monitor and there was no information regarding the monitor, he would expect for some background information and possibly some legwork to discover as to how come the resident was wearing the cardiac monitor. The physician stated it would have been reasonable for the facility to have discovered some information regarding the cardiac monitor between the resident ' s admission on 12/11/20 and 2/23/20.

During an interview with the Director of Nursing (DON) conducted on 2/25/20 at 4:22 PM she stated there should have been an order for Resident #77 to have worn the cardiac monitor, to check to make sure the monitor and leads were in place each shift, and how long the monitor was to be worn. The DON further explained if it was not known who had ordered the cardiac monitor, then she stated it was her expectation for the nursing staff to have tried to track down who ordered the monitor and what the parameters were regarding the monitor. The DON also said if the resident was non-compliant with the monitor

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F 580	Continued From page 11 she would have expected the nursing staff to contact the physician or Nurse Practitioner to make them aware of the resident ' s non-compliance and seek a clarification order regarding if the monitor should be continued or discontinued. The DON stated she was unable to find in the facility or hospital medical records who had ordered the monitor and there was no cardiac consult from the hospital nor had the resident been to a cardiologist since his admission to the facility. During an interview conducted on 2/26/20 at 12:39 PM with the Administrator she stated the information regarding cardiac monitor had been mailed to the resident ' s home address and when the POA picked up the resident ' s mail she came to the facility to get the monitor. The Administrator stated there was no information regarding the cardiac monitor in the discharge summary from the hospital.	F 580		
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	F 582		3/23/20

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	345130	A. BUILDING _____ B. WING _____	C 02/28/2020

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CURIS AT CONCORD NURSING & REHABILITATION CENTER	515 LAKE CONCORD ROAD NE CONCORD, NC 28025

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F 582	Continued From page 12 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 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 interviews, the	F 582	This Plan of Correction constitutes the	

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F 582	Continued From page 13 facility failed to provide a CMS-10055 SNF ABN (Centers for Medicare and Medicaid Services Skilled Nursing Facility Advanced Beneficiary Notice) prior to discharge from Medicare Part A skilled services to 2 of 3 residents reviewed for beneficiary protection notification (Residents #72 and #77). The findings included: 1.Resident #72 was admitted to the facility on 12/27/19 with diagnoses that included cerebral palsy, need for assistance with personal care, generalized anxiety disorder, major depressive disorder and irritable bowel syndrome. Resident #72's Minimum Data Set (MDS) admission assessment dated 12/29/19 specified the resident's cognition as being cognitively intact. Resident #72's medical record revealed a Notice of Medicare Non-Coverage Form CMS 10123-NOMNC with an effective date of coverage ending on 1/23/20. It was signed by Resident #72 on 1/21/20. Further review of the medical record showed an un-dated Advance Beneficiary Notice of Noncoverage (ABN) Form CMS - R-131 with Residents #72 ' s name and was partially filled out. The form was not signed by the resident. The medical record did not include the required Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN) Form CMS-10055. An interview was completed with the Business Manager (BM) on 2/26/20 at 1:16 pm who stated Resident #72 had Medicare Part A days remaining. She acknowledged the wrong form had been given to Resident #72 and should have	F 582	facilities allegation of compliance for the deficiencies citied in the CMA-2567 . The statement made in the plan of Corrections are not admission to and do not indicate an agreement with alleged deficiencies. This Plan of Correction is written and executed as to remain in compliance with all Federal and State regulations such that all alleged deficiencies cited have been or will be corrected by the date (s) indicated. Response to this statement of Delicense does not constitute an admission that any deficiency is accurate. No residents were named in the citation Based on the root cause analysis by the administrative staff and facility administrator it was determine that there was a lack of clear understanding of the regulatory requirement to provide a skilled Nursing Facility Advance Beneficiary Notice (SNF-ABN) prior to discharge from Medicare part A services for residents. Advance Beneficiary Notices (SNF-ABN) for residents #72 and #77 were issued and completed on 3-19-20 with required Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage. (SNF-ABN) form CMS- 10055. On 3-20-2020 a 100% audit of the last 30 days of discharges was conducted by the Social Services Director to determine others who may have been affected by the alleged deficient Practice On 3-20-2020 education was provided by the Administrator to the Social Services Director regarding the regulatory	

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F 582	Continued From page 14 been filled out completely. BM stated she was new to the role and had not been responsible for having issued Form CMS - R-131. The staff that had issued the Form CMS - R-131 is no longer at the facility. An interview was completed with the Administrator on 2/28/20 at 2:45 pm who stated it is the expectation that the required CMS forms would be given to the resident and completed in its entirety. 2. Resident #77 was admitted to the facility on 12/11/2019 with diagnoses to include Other Cerebral Infarction, Intracardiac Thrombosis, Type 2 Diabetes mellitus without complications, thrombosis of atrium, auricular appendage, and ventricle as current complications following acute myocardial infarction. Resident #77's Minimum Data Set (MDS) quarterly assessment dated 1/23/20 specified the resident ' s cognition as being cognitively intact. Resident #77's medical record revealed a Notice of Medicare Non-Coverage Form CMS 10123-NOMNC with an effective date of coverage ending on 1/24/20. Resident #77 signed the form on 1/22/20. An Advance Beneficiary Notice of Noncoverage (ABN) Form CMS - R-131 had been given to Resident #77 and signed Resident #77's representative on 1/2/20 and was partially filled out. The medical record did not include the required Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN) Form CMS-10055. An interview was completed with the Business Manager (BM) on 2/26/20 at 1:16 pm who stated	F 582	requirement for issuing an ABN. This education included the residents who remain in the facility or discharged after Medicare A services ended who require an ABN be given. Beginning 3- 23 20 the Social Services Director will maintain a log of residents who are discharged from Medicare Part A services. On this log will be the resident□s name, date Medicare Part A discharge and the date the ABN was provided. The log will be kept in a binder Beginning 3-23-2020 the administrator of the facility will review the Medicare Part A discharge binder weekly and validate that the ABN has been provided to those residents whose Medicare Part A services have ended. The administrator will sign the Medicare Part A discharge log weekly for 4 weeks and then monthly for three months. Findings will be reported to the Quality Assurance Performance Improvement committee for recommendations or modification until a pattern of compliance is achieved.	

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F 582	Continued From page 15 Resident #77 had Medicare Part A days remaining. She acknowledged the wrong form had been given to Resident #77 and should have been filled out completely. BM stated she was new to the role and had not been responsible for having issued Form CMS - R-131. The staff that had issued the Form CMS - R-131 is no longer at the facility. An interview was completed with the Administrator on 2/28/20 at 2:45 pm who stated it is the requirement the correct CMS form would be filled out and completed in its entirety.	F 582		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems.	F 636		3/23/20

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F 636	Continued From page 16 (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to complete an	F 636	This Plan of Correction constitutes the facilities allegation of compliance for the	

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F 636	Continued From page 17 admission assessment within 14 days of the admission date for 1 of 3 residents (Resident #1) reviewed for timely completion of admission Minimum Data Set (MDS) assessments. Findings included: Resident #1 was admitted to the facility on 9/24/19. Review of Resident #1 ' s MDS assessments revealed an admission assessment with an Assessment Reference Date (ARD) of 9/30/19. Further review revealed the assessment had been completed on 10/8/19. The Final Validation Report dated 10/9/19 was reviewed. The report included a warning message indicating Resident #19 ' s MDS assessment with an ARD of 9/30/19 had been completed late for the admission assessment and the completion date was more than 13 days after the admission date, 9/24/19. An interview was conducted on 2/26/20 at 11:01 AM with the MDS Coordinator. She further explained she was the only MDS Coordinator at the time and she had gotten backed up after the assessments changed on 10/1/20 to the new system of Patient Driven Payment Model (PDPM). An interview was conducted on 2/26/20 at 12:39 PM with the facility Administrator. The Administrator revealed her expectation was for MDS assessments to be completed timely and for the MDS Coordinator to follow the RAI manual.	F 636	deficiencies citied in the CMA-2567 . The statement made in the plan of Corrections are not admission to and do not indicate an agreement with alleged deficiencies. This Plan of Correction is written and executed as to remain in compliance with all Federal and State regulations such that all alleged deficiencies cited have been or will be corrected by the date (s) indicated. Response to this statement of Delicense does not constitute an admission that any deficiency is accurate. No residents were named in the citation On 2/26/2020 resident #1 Comprehensive Assessment dated 9/30/19 with a completion date of 10/8/19 was reviewed and noted completed late by the Minimum Data Set Nurse. On 3/19/2020, the Minimum Data Assessment Nurse performed Quality Improvement monitoring for all current residents with Comprehensive assessments in progress to identify any late assessments. Any issues identified were addressed. On 3/18/2020, the Minimum Data Set Nurse□s were re-educated by the Regional Minimum Data Set Nurse on timeliness of Comprehensive assessment completion. The Director of Nursing and/or Regional Minimum Data Assessment Nurse will perform Quality Improvement Monitoring of MDS Comprehensive assessments for timeliness of completion by reviewing the In Progress MDS list 3 times per week for	

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F 636	Continued From page 18	F 636	four weeks, then twice weekly for two weeks, then one time per week for two months and then one time monthly for three months. Audits will begin 3/23/2020. The Director of Nursing will report on the results of the Quality Monitoring (Audits) to the Quality Assurance Performance Improvement Committee. Findings will be reviewed by QAPI Committee monthly and Quality Monitoring (Audit) updated if changes are needed based on findings. The Quality Assurance Performance Improvement Committee meets monthly and quarterly at a minimum. Date of Compliance is 3/23/2020.	
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to complete a significant change	F 637	This Plan of Correction constitutes the facilities allegation of compliance for the	3/23/20

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F 637	Continued From page 19 Minimum Data Set (MDS) assessment for 1 of 1 residents reviewed for hospice services (Resident # 47). Findings included: A review of the medical record for Resident #47 revealed that he was admitted to the facility on 04/04/2014 with diagnoses that included malnutrition, chronic pain, depression and hypertension. The quarterly MDS dated 05/01/2019 for Resident #49did not specify the resident received hospice services during the MDS look back (review) period. The medical record and billing census of Resident #47 revealed that he was placed on hospice services on 07/10/2019. The quarterly MDS dated 08/01/2019 revealed that Resident #47 was cognitively intact and rejected care for 4 to 6 days of the MDS review time period. Resident #47 required extensive assist with bed mobility and toileting, was able to feed himself after meal set up, incontinent of bladder and bowel and received both scheduled and as needed (prn) pain medications. Resident #47 was also coded to have a poor prognosis with a life expectancy of less than 6 months, received an opioid on 7 review days and received hospice care. The care plan for Resident #47 updated on 12/11/2019 revealed in part that Resident #47 received hospice services and was at risk for social isolation and dependent for facility staff to provide cognitive stimulation interventions	F 637	deficiencies citied in the CMA-2567 . The statement made in the plan of Corrections are not admission to and do not indicate an agreement with alleged deficiencies. This Plan of Correction is written and executed as to remain in compliance with all Federal and State regulations such that all alleged deficiencies cited have been or will be corrected by the date (s) indicated. Response to this statement of Delicense does not constitute an admission that any deficiency is accurate. No residents were named in the citation On 2/26/2020, resident #47 Significant Change Assessment was scheduled for 2-26-2020 by the Minimum Data Set Nurse to reflect initiation of Hospice Services. On 3/19/2020, the Minimum Data Assessment Nurse performed Quality Improvement monitoring for all current Hospice residents to identify any resident requiring a Significant Change assessment. Any issues identified were addressed. On 3/18/2020, the Minimum Data Set Nurse s were re-educated by the Regional Minimum Data Set Nurse on timeliness of Significant Change assessment completion. The Director of Nursing and/or Regional Minimum Data Assessment Nurse will perform Quality Improvement Monitoring of MDS assessments for timeliness of completion of Significant Assessment by reviewing Hospice residents three times weekly for four weeks, then twice weekly for two	

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F 637	Continued From page 20 included to assist hospice with care and to notify hospice of any changes in status for Resident #47. On 02/25/2020 at 10:24 AM an interview was conducted with Nurse #1. Nurse #1 stated that she was not certain when hospice services started for Resident # 47 but did recall that she believed it was quite a few months ago possibly last Summer. An interview conducted with the MDS nurse on 02/25/2020 at 11:10 AM revealed that she had been employed at the facility for about the past 7 months and that she was aware that Resident # 47 received hospice services since prior to her employment. Review of the MDS assessments as well as the census billing information for Resident #47 the MDS nurse stated that a significant change MDS should have been completed for Resident #47 within 14 days of the initiation of hospice services. On 02/26/2020 at 10:10 AM an interview was conducted with the facility ' s Administrator. The Administrator stated that it was expected that significant change MDS assessments be completed as per state and federal regulations and as per the requirements in the RAI (Resident Assessment Manual) for MDS completion.	F 637	weeks, then one time per week for two months and then one time monthly for three months. Audits will begin 3/23/2020. The Director of Nursing will report on the results of the Quality Monitoring (Audits) to the Quality Assurance Performance Improvement Committee. Findings will be reviewed by QAPI Committee monthly and Quality Monitoring (Audit) updated if changes are needed based on findings. The Quality Assurance Performance Improvement Committee meets monthly and quarterly at a minimum. Date of Compliance is 3/23/2020.	
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.	F 638		3/23/20

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F 638	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to complete a quarterly resident assessment within 14 days of the Assessment Reference Date (ARD) for 2 of 2 residents (Resident #26 and Resident #55) reviewed for timely completion of quarterly Minimum Data Set (MDS) assessments. Findings included: 1. Resident #26 was originally admitted to the facility on 2/10/18 and was most recently readmitted on 3/5/18. Review of Resident #26 ' s MDS assessments revealed a quarterly assessment with an Assessment Reference Date (ARD) of 10/14/19. Further review revealed the assessment had been completed on 11/3/19. The Final Validation Report dated 11/4/19 was reviewed. The report included a warning message indicating Resident #26 ' s MDS assessment with an ARD of 10/14/19 had been completed late and the completion date was more than 14 days after the ARD. An interview was conducted on 2/26/20 at 11:01 AM with the MDS Coordinator. She reviewed Resident #26 ' s quarterly MDS assessment dated 10/14/19 and stated it had been completed on 11/3/19, which was late. She stated she had not completed the assessment, there was another MDS Coordinator who was helping from another facility. She further explained she was the only MDS Coordinator at the time and she had gotten backed up after the assessments	F 638	This Plan of Correction constitutes the facilities allegation of compliance for the deficiencies citied in the CMA-2567 . The statement made in the plan of Corrections are not admission to and do not indicate an agreement with alleged deficiencies. This Plan of Correction is written and executed as to remain in compliance with all Federal and State regulations such that all alleged deficiencies cited have been or will be corrected by the date (s) indicated. Response to this statement of Delicense does not constitute an admission that any deficiency is accurate. No residents were named in the citation On 2/26/2020 resident #26 and 55 Quarterly Assessment dated 10/14/19 and 1/3/2020 with a completion date of 11/3/19 and 2/4/2020 respectively were reviewed and noted completed late by the Minimum Data Set Nurse. On 3/19/2020, the Minimum Data Assessment Nurse performed Quality Improvement monitoring for all current residents with Quarterly assessments in progress to identify any late assessments. Any issues identified were addressed. On 3/18/2020, the Minimum Data Set Nurse s were re-educated by the Regional Minimum Data Set Nurse on timeliness of Quarterly assessment completion. The Director of Nursing and/or Regional Minimum Data Assessment Nurse will perform Quality	

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F 638	Continued From page 22 changed on 10/1/20 to the new system of Patient Driven Payment Model (PDPM). The MDS Coordinator stated she had 14 days to finish the assessment from the ARD. An interview was conducted on 2/26/20 at 12:39 PM with the facility Administrator. The Administrator revealed her expectation was for MDS assessments to be completed timely and for the MDS Coordinator to follow the RAI manual. 2. Resident #55 was admitted to the facility on 11/21/18. Review of Resident #55 ' s MDS assessments revealed a quarterly assessment with an ARD of 1/3/20. Further review revealed the assessment had been completed on 2/4/20. The Final Validation Report dated 2/4/20 was reviewed. The report included a warning message indicating Resident #55 ' s MDS assessment with an ARD of 1/3/20 had been completed late and the completion date was more than 14 days after the ARD. An interview was conducted on 2/26/20 at 11:01 AM with the MDS Coordinator. She stated she didn ' t know why the assessment for Resident #55 had a completed date of 2/4/20 and she did not remember when she had completed the assessment. The MDS Coordinator stated she had 14 days to finish the assessment from the ARD. During an interview, which took place on 2/26/20, the facility MDS Consultant explained the quarterly assessment for Resident #55 had been attempted to be transmitted prior to 2/4/20 but it	F 638	Improvement Monitoring of MDS Quarterly assessments for timeliness of completion by reviewing the In Progress MDS list 3 times per week for four weeks, then twice weekly for two weeks, then one time per week for two months and then one time monthly for three months. Audits will begin 3/23/2020. The Director of Nursing will report on the results of the Quality Monitoring (Audits) to the Quality Assurance Performance Improvement Committee. Findings will be reviewed by QAPI Committee monthly and Quality Monitoring (Audit) updated if changes are needed based on findings. The Quality Assurance Performance Improvement Committee meets monthly and quarterly at a minimum. Date of Compliance is 3/23/2020.	

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F 638	Continued From page 23 had been rejected and he provided a copy the validation report with the rejection. He stated they were unable to complete and submit the assessment report within 14 days of the ARD because the report had been rejected because of an error in the assessment. An interview was conducted on 2/26/20 at 12:39 PM with the facility Administrator. The Administrator revealed her expectation was for MDS assessments to be completed timely and for the MDS Coordinator to follow the RAI manual.	F 638		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.	F 640		3/23/20

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F 640	Continued From page 24 §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to complete and submit a discharge assessment within 14 days of the discharge date ate for 1 of 3 residents (Resident #1) reviewed for Resident Assessment. Findings included: Resident #1 was admitted to the facility on 9/24/19 and was discharged on 11/9/19. Review of Resident #1 ' s Minimum Data Set (MDS) assessments revealed a discharge return	F 640	This Plan of Correction constitutes the facilities allegation of compliance for the deficiencies citied in the CMA-2567 . The statement made in the plan of Corrections are not admission to and do not indicate an agreement with alleged deficiencies. This Plan of Correction is written and executed as to remain in compliance with all Federal and State regulations such that all alleged deficiencies cited have been or will be corrected by the date (s) indicated. Response to this statement of Delicense does not constitute an admission that any	

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F 640	Continued From page 25 not anticipated assessment with an Assessment Reference Date (ARD) of 11/9/19. Further review revealed the assessment had been completed on 2/19/20. The Final Validation Report dated 2/24/20 was reviewed. The report included a warning message indicating Resident #1 ' s MDS assessment with an ARD of 11/9/19 had been completed late for the discharge return not anticipated assessment had been completed late and the completion date was more than 14 days after the date of discharge. An interview was conducted on 2/26/20 at 11:01 AM with the MDS Coordinator. She explained the discharge assessment for Resident #1 was done and the resident was discharged. She stated when she had reviewed the missing assessments report it had shown the discharge assessment for Resident #1 had not been completed and it was late when she had opened it. An interview was conducted on 6/26/20 at 12:39 PM with the facility Administrator. The Administrator revealed her expectation was for MDS assessments to be completed timely and for the MDS Coordinator to follow the RAI manual.	F 640	deficiency is accurate. No residents were named in the citation On 2/26/2020 resident #1□ Discharge Assessment dated 11/19/19 was reviewed and noted Transmitted late by the Minimum Data Set Nurse. On 3/19/2020, the Minimum Data Assessment Nurse performed Quality Improvement monitoring for all Validation Reports for the past 30 days to identify any late transmissions. Any issues identified were addressed. On 3/18/2020, the Minimum Data Set Nurse□s were re-educated by the Regional Minimum Data Set Nurse on timeliness of assessment transmission. The Director of Nursing and/or Regional Minimum Data Assessment Nurse will perform Quality Improvement Monitoring of MDS assessment for timeliness of transmission by reviewing the Validation Report 3 times per week for four weeks, then twice weekly for two weeks, then one time per week for two months and then one time monthly for three months. Audits will begin 3/23/2020. The Director of Nursing will report on the results of the Quality Monitoring (Audits) to the Quality Assurance Performance Improvement Committee. Findings will be reviewed by QAPI Committee monthly and Quality Monitoring (Audit) updated if changes are needed based on findings. The Quality Assurance Performance Improvement Committee meets monthly	

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F 640	Continued From page 26	F 640	and quarterly at a minimum. Date of Compliance is 3/23/2020	
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 observations, record review and resident and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessments for Antipsychotic Medications (Resident #64) and for tobacco use (Resident #292), for 2 of 20 sampled residents reviewed for MDS accuracy. The findings included: 1. Resident #64 was admitted to the facility on 1/29/16. Resident #52's cumulative list of diagnoses included: Dementia with behaviors, Alzheimer's, psychotic disorder with delusions, anxiety, and depression. The MDS quarterly assessment with an Assessment Reference Date (ARD) of 1/14/20 indicated Resident #64 was coded as having had received antipsychotic medication for seven days of the seven day assessment period. Further review of the MDS assessment revealed the resident was coded as having not received antipsychotic medications since admission/entry or the prior assessment. A review of the care plan for Resident #64, which	F 641	This Plan of Correction constitutes the facilities allegation of compliance for the deficiencies citied in the CMA-2567 . The statement made in the plan of Corrections are not admission to and do not indicate an agreement with alleged deficiencies. This Plan of Correction is written and executed as to remain in compliance with all Federal and State regulations such that all alleged deficiencies cited have been or will be corrected by the date (s) indicated. Response to this statement of Delicense does not constitute an admission that any deficiency is accurate. No residents were named in the citation On 2-28-2020, resident #64 MDS Quarterly assessment dated 1-14-2020 was modified to accurately reflect the residents use of Antipsychotic Medication by the Minimum Data Set Nurse . On 2-26 -20 resident #292 MDS admission assessment was modified to accurately reflect the residents smoking status by the Minimum Data Set Nurse. was updated to accurately reflect the residents use of Antipsychotic Medication by the Minimum	3/23/20

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F 641	Continued From page 27 was most recently updated on 1/29/20 revealed the following focus area: Resident #64 was receiving multiple psychotropic medications (antipsychotic, antidepressant, and anti-anxiety) for the diagnoses of dementia with behavioral disturbance, psychosis, depression, anxiety, and delusions. A review of the Medication Admission Record (MAR) for Resident #64 for the period of 1/08/20 through 1/14/20 revealed the resident received antipsychotic medication for each day of the assessment period. During an interview conducted with the MDS Coordinator on 2/26/20 at 10:58 AM she stated she should have coded the resident as having received antipsychotic medication for the 1/14/20 quarterly assessment. An interview was conducted on 2/26/20 at 12:39 PM with the facility Administrator. The Administrator revealed her expectation was for MDS assessments to be completed accurately and for the MDS Coordinator to follow the Resident Assessment Instrument (RAI) manual. 2. Resident #292 was admitted to the facility on 2/4/20 with a diagnosis of Low back pain, other chronic pain and acute kidney failure. Resident #292 ' s admission Minimum Data Set (MDS) assessment dated 2/6/20 coded the resident as being moderately impaired. Health conditions related to tobacco use was marked ' No ' on the MDS assessment. During the survey, the facility provided a list of current residents who smoke and Resident #292 was included on the list.	F 641	Data Set nurse. On 3/19/2020, the Minimum Data Set Nurse performed Quality Improvement monitoring of the most recent assessment for resident□s currently receiving Antipsychotic medications and the most recent Comprehensive Assessment of Residents who currently smoke for item accuracy. Any issues identified were addressed. On 3/18/2020, the Minimum Data Set Nurse□s were re-educated by the Regional Minimum Data Set nurse on: a. N0410 □ Antipsychotic Medication use, and b. J1300 □ Tobacco Use The Director of Nursing and/or Regional Minimum Data Assessment Nurse will perform Quality Improvement Monitoring of MDS assessments for Accuracy of MDS Assessments □ to include Antipsychotic Medication use and Tobacco Use □ on four random MDS assessments three times per week for four weeks, then one time per week for two months and then one time monthly for three months. Audits will begin 3/23/2020. The Director of Nursing will report on the results of the Quality Monitoring (Audits) to the Quality Assurance Performance Improvement Committee. Findings will be reviewed by QAPI Committee monthly and Quality Monitoring (Audit) updated if changes are needed based on findings. The Quality Assurance Performance	

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F 641	Continued From page 28 An observation of Resident #292 smoking was conducted on 02/24/20 at 2:10 pm. Resident #292 stated he had been smoking at the facility since he was admitted. An interview was conducted on 2/25/20 at 11:00 am with the Unit Manager (UM). She indicated that a smoking assessment was completed for Resident #292 upon admission. She stated when a resident was admitted a staff member observe the resident smoking to ensure the resident would be a safe smoker. A smoking assessment was completed on Resident #292 on 2/4/20. An interview was conducted on 2/25/20 at 4:15 pm with the facility's MDS Coordinator. During the interview, the MDS Coordinator reviewed Resident #292's 2/6/20 admission MDS assessment. She confirmed Health conditions related to tobacco use was marked no. The MDS Coordinator reported she would review the information. A follow-up interview was conducted on 2/26/20 at 10:08 am with the MDS Coordinator. The MDS Coordinator reported a review of Resident #292's MDS and the changes to Health conditions - Tobacco use had been revised and that it was an oversite. A review of the MDS admission assessment showed a revision was made on 2/25/20 at 5:55 pm. to reflect Resident #292 did use tobacco. An interview was conducted with the Administrator on 2/28/20 at 2:45 pm who indicated the MDS assessment should be accurate and correspond with the residents	F 641	Improvement Committee meets monthly and quarterly at a minimum	

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F 641	Continued From page 29 needs or what he was doing.	F 641		
F 655 SS=E	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. (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:	F 655		3/23/20

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F 655	Continued From page 30 (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 record review, resident and staff interviews, the facility failed to provide a copy or summary of the baseline care plan to the resident and/or resident representative for 4 of 4 residents reviewed for baseline care plans. (Resident #72, #290, #292, and Resident #15) The findings included: 1. Resident #72 was admitted to the facility on 12/27/19 with diagnoses that included cerebral palsy, need for assistance with personal care, generalized anxiety disorder, major depressive disorder irritable bowel syndrome with constipation. Resident #72 ' s Minimum Data Set (MDS) admission assessment dated 12/29/19 specified the resident ' s cognition as being cognitively intact. Resident #72 ' s medical record revealed a baseline care plan was completed on 12/30/19. A request was made to the MDS coordinator on 2/25/20 for a copy of Resident #72's baseline care plan with signatures. Resident #72's baseline care plan was reviewed on 2/26/20 at 9:00 am and it did not include	F 655	This Plan of Correction constitutes the facilities allegation of compliance for the deficiencies citied in the CMA-2567 . The statement made in the plan of Corrections are not admission to and do not indicate an agreement with alleged deficiencies. This Plan of Correction is written and executed as to remain in compliance with all Federal and State regulations such that all alleged deficiencies cited have been or will be corrected by the date (s) indicated. Response to this statement of Delicense does not constitute an admission that any deficiency is accurate. No residents were named in the citation On 2/26/2020, residents #72, 290, 292, and 15□ Baseline Care Plans were reviewed by the Minimum Data Set Nurse and determined not presented timely to the residents for review. On 3/20/2020, the Minimum Data Set Nurse performed Quality Improvement monitoring of all resident admissions within the last 30 days for Baseline Care Plan review and signature. Any issues identified were addressed.	

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F 655	Continued From page 31 Resident #72's signature. An interview was completed with Resident #72 on 2/26/20 at 9:45 am who indicated she did not remember receiving a copy or summary of her care plan. An interview was completed with the Director of Nursing (DON) on 2/26/2020 at 10:58 am. DON stated she had met with the regional consultant on 2/25/20 who indicated that all residents or representatives must sign and receive a copy of the base line care plan. DON stated she was not aware of the process and Resident #72 did not sign or receive her care plan. DON stated, "We now know this must be done in the future". An interview was completed with the Administrator on 2/28/20 at 2:45 pm who stated base line care plans should have been signed and shared with the family or the resident per the Resident Assessment Manual. 2. Resident #290 was admitted to the facility on 2/15/2020 with diagnoses to include Type 2 Diabetes mellitus without complications. Resident #290 Minimum Data Set (MDS) admission assessment dated 2/17/20 specified the resident ' s cognition was moderately impaired. Resident #290's medical record revealed a baseline care plan was completed on 2/18/20. A request was made to the MDS coordinator on 2/25/20 for a copy of Resident #290 ' s baseline care plan with signatures.	F 655	On 3/18/2020, Minimum Data Set Nurses were re-educated by the Regional Minimum Data Set Nurse on Baseline Care Plan review with the Resident and RP. The Director of Nursing and/or Regional Minimum Data Assessment Nurse will perform Quality Improvement Monitoring of Baseline Care Plans for timely review with Residents and RP□s on four Resident admissions three times per week for four weeks, then one time per week for two months and then one time monthly for three months. Audits will begin 3/23/2020. The Director of Nursing will report on the results of the Quality Monitoring (Audits) to the Quality Assurance Performance Improvement Committee. Findings will be reviewed by QAPI Committee monthly and Quality Monitoring (Audit) updated if changes are needed based on findings. The Quality Assurance Performance Improvement Committee meets monthly and quarterly at a minimum. Date of Compliance is 3/23/2020.	

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F 655	Continued From page 32	F 655		

Resident #290's baseline care plan was reviewed on 2/26/20 at 9:00 am and it did not include Resident #290 ' s signature or representative signature.

An interview with Resident #290 was completed on 2/26/20 at 9:43 am who indicated he did not remember if he or his representative received a copy of his care plan.

An interview was completed with the Director of Nursing (DON) on 2/26/2020 at 10:58 am. DON stated she had met with the regional consultant on 2/25/20 who indicated that all residents or representatives must sign and receive a copy of the base line care plan. DON sated she was not aware of the process and Resident #290 did not sign or receive his care plan. DON stated, "We now know this must be done in the future".

An interview was completed with the Administrator on 2/28/20 at 2:45 pm who stated base line care plans should have been signed and shared with the family or the resident per the Resident Assessment Manual.

3. Resident #292 was admitted to the facility on 2/4/20 with a diagnoses of Low back pain, other chronic pain, acute kidney failure.

Resident #292 Minimum Data Set (MDS) admission assessment dated 2/6/20 specified the resident ' s cognition was moderately impaired.

Resident #292's medical record revealed a baseline care plan was completed on 2/5/20.

A request was made to the MDS coordinator on 2/25/20 to obtain a copy of Resident #292 ' s

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baseline care plan with signatures.

Resident #292's baseline care plan was reviewed on 2/26/20 at 9:00 am and it did not include Resident #292 ' s signature or representative signature.

An interview was completed with Resident #292 on 2/26/20 at 2:47 pm who indicated he did not sign or receive a copy of his care plan.

An interview was completed with the Director of Nursing (DON) on 2/26/2020 at 10:58 am. DON stated she had met with the regional consultant on 2/25/20 who indicated that all residents or representatives must sign and receive a copy of the base line care plan. DON stated we were not aware of the process and Resident #292 did not sign or receive his care plan. DON stated, "We now know this must be done in the future".

An interview was completed with the Administrator on 2/28/20 at 2:45 pm who stated base line care plans should have been signed and shared with the family or the resident per the Resident Assessment Manual.
4. Resident #15 was admitted to the facility on 12/27/19 with diagnoses of pressure ulcer to sacrum and chronic kidney disease.

A review of an Admission Minimum Data Set (MDS) Assessment dated 1/2/2020 revealed Resident #15 was cognitively intact.

Resident #15's baseline care plan was dated 12/27/19. The care plan signature lines were blank indicating the care plan had not been reviewed with the Resident and/or the Resident's Representative.

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F 655	Continued From page 34 During an interview with the Minimum Data Set (MDS) Coordinator on 2/26/2020 at 9:59 am she stated the residents are not given a copy of their 48-hour baseline care plan. An interview with the Director of Nursing on 2/26/2020 at 10:58 am revealed she was not aware the 48-hour baseline care plan should be reviewed, and a copy given to the resident or the resident representative. During an interview with the Unit Manager on 2/26/2020 at 11:24 am she stated she did not give the resident or the responsible party a copy of the care plan or review the care plan with them. The Unit Manager stated she had never been told she should give the resident or resident's responsible party a copy of the care plan or go over it with them. During an interview with the Administrator on 2/28/2020 at 2:42 pm she stated the 48-hour baseline care plan should be reviewed with the resident or resident representative per the regulation.	F 655		
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	F 656		3/23/20

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F 656	Continued From page 35 assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, observations resident and staff interviews, the facility failed to develop a care plan with interventions and goals for a resident who smoked for 1 of 1 resident reviewed for accidents. (Resident #292)	F 656	This Plan of Correction constitutes the facilities allegation of compliance for the deficiencies citied in the CMA-2567 . The statement made in the plan of Corrections are not admission to and do not indicate an agreement with alleged deficiencies.	

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F 656	Continued From page 36 The finding included: Resident #292 was admitted to the facility on 2/4/20 with a diagnoses of Low back pain, other chronic pain, other abnormalities of gait and mobility. During the survey, the facility provided a list of current residents who smoke and Resident #292 was included on the list. Resident #292's medical record revealed a smoking assessment was completed on 2/4/20 and did not require Resident #292 to be supervised when smoking. A baseline care plan was completed on 2/5/20 revealed resident was a smoker. Resident #292 Minimum Data Set (MDS) admission assessment dated 2/6/20 specified the resident ' s cognition was moderately impaired. Health conditions related to tobacco use was marked No on the MDS assessment. The care plan dated 2/10/20 did not identify any interventions or goals related to Resident #292 ' s smoking or tobacco use. An observation of Resident #292 smoking on 02/24/20 at 02:10 pm was conducted. Resident #292 stated he had been smoking at the facility since he arrived. An interview was conducted on 2/25/20 at 11:00 am with the Unit Manager (UM). She indicated that a smoking assessment was completed for Resident #292 upon admission. She stated when a resident was admitted, the resident and a staff member observe the resident smoking to ensure	F 656	This Plan of Correction is written and executed as to remain in compliance with all Federal and State regulations such that all alleged deficiencies cited have been or will be corrected by the date (s) indicated. Response to this statement of Delicense does not constitute an admission that any deficiency is accurate. No residents were named in the citation On 2-25-2020, resident #292 Care Plan was updated to accurately reflect the residents use of Tobacco by the Minimum Data Set Nurse. On 3/19/2020, the Minimum Data Set Nurse performed Quality Improvement monitoring of all Care Plans on Residents who use Tobacco for Care Plan accuracy. Any issues identified were addressed. On 3/18/2020, the Minimum Data Set Nurses were re-educated by the Regional Minimum Data Set Nurse on Care Planning of Residents who use Tobacco to accurately reflect the resident. The Director of Nursing and/or Regional Minimum Data Assessment Nurse will perform Quality Improvement Monitoring of Care Plans for Residents who use Tobacco behaviors on four Comprehensive assessments three times per week for four weeks, then one time per week for two months and then one time monthly for three months. Audits will begin 3/23/2020. The Director of Nursing will report on the	

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F 656	Continued From page 37 the resident would be a safe smoker. An interview was conducted on 2/25/20 at 4:15 PM with the facility's MDS Coordinator. During the interview, the MDS Coordinator reviewed Resident #292's 2/6/20 admission MDS assessment. She confirmed Health conditions related to tobacco use was marked No. At that time, the MDS coordinator was made aware there was no care plan intervention for Resident #292 related to smoking or tobacco use. The MDS Coordinator reported she would review the information. A follow-up interview was conducted on 2/26/20 at 10:08 am with the MDS Coordinator. The MDS Coordinator reported a review of Resident #292's care plan and stated the care plan had been revised to reflect care plan interventions for smoking. Resident #292's care plan was reviewed on 2/26/20 at 10:15 am. The care plan dated 2/10/20 was revised on 2/25/20 at 5:55 pm to reflect care plan interventions for smoking. The goal stated "Resident #292 is a smoker, the resident will not suffer injury from unsafe smoking practices through the review date. Instruct resident about the facility policy on smoking: locations, times, safety concerns. Monitor oral hygiene, offer smoking apron as ordered resident to smoke in designated smoking area". An interview was completed with the Director of Nursing (DON) on 2/26/20 at 10:58 am who stated that Nursing and the MDS coordinator would develop the care planning goals. DON reviewed the printed copy of the base line care plan and stated the electronic version of the	F 656	results of the Quality Monitoring (Audits) to the Quality Assurance Performance Improvement Committee. Findings will be reviewed by QAPI Committee monthly and Quality Monitoring (Audit) updated if changes are needed based on findings. The Quality Assurance Performance Improvement Committee meets monthly and quarterly at a minimum. Date of Compliance is 3/23/2020.	

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F 656	Continued From page 38 baseline care plan did not populate the next section regarding Smoking Care Planning when yes was selected was the resident a smoker. DON stated she had not printed off the baseline care plan but would have seen this did have a section for Care Planning. DON stated this was a new form as of November 1, 2019. An interview was completed with the Administrator on 2/28/20 at 2:45 pm who stated that she would expect the care plan be accurate with the needs and accuracy of the resident.	F 656		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, manufacturer ' s manual review, and resident and staff interviews, the facility failed to clean respiratory equipment for 1 of 1 resident reviewed for respiratory care (Resident #12). The findings included: The manufacturer ' s user ' s guide for the Continuous Positive Airway Pressure (CPAP) cleaning recommendations were to clean the water tub and air tubing weekly in warm water	F 695	This Plan of Correction constitutes the facilities allegation of compliance for the deficiencies citied in the CMA-2567 . The statement made in the plan of Corrections are not admission to and do not indicate an agreement with alleged deficiencies. This Plan of Correction is written and executed as to remain in compliance with all Federal and State regulations such that all alleged deficiencies cited have been or will be corrected by the date (s) indicated. Response to this statement of Delicense	3/23/20

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F 695	Continued From page 39 with mild detergent, rinse the water tub and air tubing thoroughly and allow to dry out of direct sunlight and/or heat. Further review of the manual revealed a recommendation to clean the air filter and replace it at least every six months. In addition, replace the air filter more often if there are any holes or blockages by dirt or dust and the air filter was not washable or reusable. Regarding the mask, the recommendations are to handwash the mask components with warm water with a mild soap, rinse with drinking quality water, and allowed to air dry, daily/after each use. Resident #12 was admitted to the facility on 12/14/18. The resident ' s cumulative diagnoses included: Dementia, chronic obstructive pulmonary disease (COPD), obstructive sleep apnea, restlessness and agitation. Resident #12 ' s most recent Minimum Data Set assessments revealed an annual comprehensive assessment with an Assessment Reference Date of 12/17/19. Review of the assessment revealed the resident was coded as having moderate cognitive impairment and was not coded as having used a CPAP device. Resident #12 ' s care plan, which was last reviewed on 2/17/20, revealed the resident had a care plan for the use of a CPAP machine at night related to ineffective gas exchange and secondary to respiratory illness. Review of the interventions revealed no recommendations or information regarding cleaning, servicing, or maintenance of the machine. Resident #12 ' s Medication Administration Record (MAR) for 2/1/20 through 2/24/20 was reviewed. The review revealed the resident had	F 695	does not constitute an admission that any deficiency is accurate. On 2-25-2020 the Continues Positive Airway Pressure machine filter was changed and will be changed per facility policy. Facility policy is per manufacturer's recommendation (every six months and as needed). An ordered was confirmed and written on 3-20-20 for cleaning Continues Positive Airway Pressure mask and tubing daily. resident # 12 CPAP cleaning of masks and tubing was provided as ordered for Resident # 12 on (3-20-20). An audit of all residents with CPAP Respiratory equipment was completed to ensure that cleaning is provided as ordered by the physician. Audit completed on 3-20-20 by Director of Nursing A Visual audit of residents was completed by the DON on 3-20-20 to validate a resident that is receiving CPAP Respiratory therapy equipment has an order and those residents with an order for CPAP Respiratory therapy equipment are receiving it. On 3-20-2020 Licensed staff educated by Director of Nursing or/Unit Manager regarding the importance of following physician orders for maintenance and cleaning of CPAP Respiratory equipment and ensuring those residents with orders	

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F 695	Continued From page 40 an order, dated 1/20/20, to receive have a CPAP on at night and remove in the morning. The application and removal of the CPAP was signed by several nurses for the reviewed period. An observation conducted in conjunction with an interview with Resident #12 in his room, on 2/23/20 at 12:05 PM, revealed the CPAP machine, tubing, and mask on the nightstand next to the resident ' s bed. Closer observation of the CPAP machine revealed a buildup of whitish/gray dust and debris over a series of holes on the lower left side of the machine. Further observation revealed the facial mask connected to the tubing had dried white debris and white flakes on the inside, mouth and nose facing, part of the mask. The resident stated he had not used the CPAP machine in a few nights because he did not have water to put into it. A bottle of undated water for the CPAP machine was observed on the upper shelf of the nightstand. A second observation conducted in conjunction with an interview with Resident #12 in his room, on 2/24/20 at 11:57 AM, revealed the CPAP machine, tubing, and mask on the nightstand next to the resident ' s bed. Closer observation of the CPAP machine revealed a buildup of whitish/gray dust and debris over a series of holes on the lower left side of the machine. Further observation revealed the facial mask connected to the tubing had dried white debris and white flakes on the inside, mouth and nose facing, part of the mask. Inspection of the bottom of the CPAP machine revealed a service sticker which had a service date for preventative maintenance and safety inspection of May 2019 and due date for the next service of November	F 695	for maintenance and cleaning of CPAP are receiving it. Audits will be conducted by Director of Nursing/Nurse Managers to monitor residents with CPAP Respiratory equipment to ensure maintenance and cleaning of CPAP respiratory equipment is provided and with an order by the physician. This audit will be conducted on all residents with CPAP Respiratory equipment 5 x per week x 12 weeks Effective 3-20-2020 the director of nursing will report the findings of the audits and observations to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remains in compliance	

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2019. The sticker also contained the service company ' s contact information. The resident stated he had used the CPAP machine last night and there was a dated bottle of water to be used for the CPAP machine on the top shelf of the resident ' s nightstand.

A third observation conducted in the room of Resident #12 in conjunction with an interview with the Director of Nursing (DON), on 2/25/20 at 9:49 AM, revealed the CPAP machine, tubing, and mask on the nightstand next to the resident ' s bed. Closer observation of the CPAP machine revealed a buildup of whitish/gray dust and debris over a series of holes on the lower left side of the machine. Further observation revealed the facial mask connected to the tubing had dried white debris and white flakes on the inside, mouth and nose facing, part of the mask. The DON stated the mask did not appear clean and appeared as it needed to have been cleaned with soap and water. The DON stated the mask was supposed to have been cleaned weekly and it did not appear as it had been cleaned weekly. The DON stated second shift should have been cleaning the mask when they put water in the well tub for the night or third shift should clean the mask and the tubing. The DON stated there was no routine schedule for cleaning the tubing and the mask. The DON stated the mask would get cleaned at the sink in the bathroom and then it would be dried with paper towels. The DON further explained the resident did not clean the mask and tubing nor did another facility staff member outside of nursing.

A phone interview was conducted on 2/25/20 at 1:12 PM with a service technician from the service company on the resident ' s CPAP

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F 695	Continued From page 42	F 695		

machine. The technician stated since October 2019, he had not received information from the facility regarding servicing their CPAP machines and he had not been to the facility to conduct service on a machine in November of 2019. The service technician stated in addition to changing the filters they would also make sure all of the pressure settings in the machine were set up correctly and the right amount of pressure was being produced.

A fourth observation conducted in the room of Resident #12 in conjunction with an interview with the Administrator, on 2/25/20 at 2:14 PM, revealed the CPAP machine, tubing, and mask on the nightstand next to the resident ' s bed. Closer observation of the CPAP machine revealed a buildup of whitish/gray dust and debris over a series of holes on the lower left side of the machine. Further observation revealed the facial mask connected to the tubing had dried white debris and white flakes on the inside, mouth and nose facing, part of the mask. The air filter cover was opened which revealed a small air filter visibly built up with white/gray dust and debris to the point the dust was built up in the pattern of the vent holes on the filter cover. The Administrator stated the filter had a buildup of gray/white dust matter, and it appeared to need to either be cleaned or replaced. The Administrator stated it was her expectation for to follow the manufacturer ' s recommendations regarding care and maintenance of the CPAP machine.

A second interview was conducted with the DON on 2/25/20 at 2:18 PM and she stated it was her expectation to follow the manufacturer ' s guidelines. The DON further explained the facility did not have filters on hand to replace the filter in

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F 695	Continued From page 43 the CPAP machine but would discuss ordering the filters with central supply. The DON also stated there used to be a Respiratory Therapist (RT) company who would come out to the facility prior to October 2019 and service the facility ' s CPAP machines. The RT company checked the filters and would also check the settings on the CPAP machine to make sure they were correct. During an interview with the Administrator on 2/26/20 at 12:39 PM she stated the facility would be following their policy titled, Infection Control Policy: Respiratory Equipment, and her expectation was for the facility staff to follow the policy regarding care and filter changes for the CPAP machine. The Administrator stated there was not information in the policy regarding changing the filter for a CPAP machine and she would follow up with the nursing department.	F 695		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist	F 756		3/23/20

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F 756	Continued From page 44 during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, and staff and pharmacist interviews the facility's pharmacy consultant failed to identify and report an irregularity regarding a critically high Vancomycin Level during a resident's medication review for 1 of 4 residents reviewed for unnecessary medications (Resident #145). Findings included: Resident #145 was admitted to the facility on 2/6/2020 with diagnoses of metabolic encephalopathy, osteomyelitis, sepsis, diabetes and stage III chronic kidney disease. A physician's order dated 2/6/2020 stated,	F 756	This Plan of Correction constitutes the facilities allegation of compliance for the deficiencies citied in the CMA-2567 . The statement made in the plan of Corrections are not admission to and do not indicate an agreement with alleged deficiencies. This Plan of Correction is written and executed as to remain in compliance with all Federal and State regulations such that all alleged deficiencies cited have been or will be corrected by the date (s) indicated. Response to this statement of Delicense does not constitute an admission that any deficiency is accurate. Resident #145 was transferred to the local	

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"Vancomycin Hydrochloride Injection solution reconstituted 1 gram intravenously two times a day for Methicillin Resistant Staphylococcus Aureus (MRSA) until 3/2/2020" by the Primary Physician.

A physician's order dated 2/10/2020 specified Vancomycin Trough (a blood test to check the Vancomycin level in Resident #145's blood) was to be administered 30 minutes prior to Vancomycin administration every Monday and the results were to be faxed to the Infectious Disease Physician at the Infectious Disease Center within 24 hours of drawing specimen.

A Vancomycin Trough collected on 2/10/2020 and marked reported by the laboratory on 2/10/2020 revealed Resident #145's Vancomycin level was critical at 41.52 micrograms/milliliter (mcg/ml) with a normal reference range of 10.00 to 20.00 mcg/ml.

An interview was conducted with the Laboratory Supervisor on 2/27/2020 at 1:45 pm. The Laboratory Supervisor stated Resident #145's 2/10/2020 Vancomycin Trough level was processed on 2/10/2020 at 5:15 pm and was released on the laboratory website at 6:19 pm on 2/10/2020. The Laboratory Supervisor stated the facility had access to the results at that time. The Laboratory Supervisor stated once a critical laboratory level is noted they immediately call the Nurse at the facility. She stated the Laboratory called the facility numerous times but could not get through because no one answered the facility's phone. The Laboratory Supervisor also stated on 2/10/2020 the Laboratory faxed Resident #145's laboratory results to the facility as well.

hospital for further evaluation and will not be readmitting.

All residents on requiring medications that require lab monitoring have the potential to be affected. As a result, an audit on all residents on medications requiring additional lab assessments prior to administering medication will be conducted 2/27/20. All licensed nursing staff will be educated on reading labs and the reporting process for critical labs prior to administration of medications 2/26/20. On 2/28/20 The pharmacist consultant was educated on reviewing labs during her monthly review of the electronic medical record.

The lab results for resident #145 were not scanned into the medical record at the time of the pharmacist consultant review. Labs for medication requiring lab monitoring will be drawn per order and results scanned into medical records after review by facility physician.

The Director of Nursing Services, or designee, will audit all potentially affected residents lab results and documentation of communication between the facility and physician regarding critical labs 5 times a week x 4 weeks, then 3 times a week x 4, then weekly x 1 month or until corrective action is achieved.

The pharmacy report along with a monthly lab order listing report will be reviewed monthly by the Director of Nursing, Unit Manager or Supervisor. Any labs for

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F 756	Continued From page 46 Resident #145's medical record revealed on 2/10/2020 there was no indication the Infectious Disease Physician at the Infectious Disease Center or the resident's physician was notified of the resident's critically high Vancomycin level of 41.52 milligrams/milliliter. Additionally, there was no physician's order written on 2/10/2020 to stop the administration of the resident's Vancomycin twice a day based on the resident's critically high Vancomycin level. Review of the Pharmacist's Medication Review dated 2/12/2020 for Resident #145 revealed the laboratory results were reviewed and no irregularities were found. The pharmacy review did not mention the resident's 2/10/2020 critical Vancomycin level of 41.52 mcg/ml. An interview with the facility's Consultant Pharmacist on 2/28/2020 at 10:48 am revealed she reviewed Resident #145's medications on 2/12/2020, but was not informed the resident had a critical Vancomycin Trough of 41.52 mcg/ml on 2/10/2020. The Pharmacist stated she was aware Resident #145 was on Vancomycin, but the pharmacy was not involved in dosing Resident #145's Vancomycin since the Infectious Disease Clinic was following him.	F 756	medication monitoring not identified on pharmacy report will be addressed. Findings will be reviewed with the administrator weekly. Results will be discussed and addressed as needed during the facility□s monthly Quality Assessment and Performance Improvement (QAPI) meeting.	
F 757 SS=J	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including	F 757		2/28/20

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F 757	Continued From page 47 duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff, Nurse Practitioner, Primary Physician, Medical Director, Infectious Disease Nurse and Infectious Disease Physician and laboratory staff interviews the facility failed to stop the administration of an intravenous antibiotic for 9 days after a critically high laboratory result was available for the facility to review and failed to obtain an ordered laboratory test for the antibiotic for 1 of 4 residents reviewed for unnecessary medications (Resident #145). Resident #145 was transferred to the hospital for evaluation and treatment. At the hospital the resident had a critically elevated Vancomycin Level of 87.3 micrograms per milliliters, a critically elevated Creatinine level of 7.07 milligrams per deciliter, was diagnosed with acute renal failure and placed in the hospital's Intensive Care Unit. At the time of the survey, Resident #145 remained in the hospital with required ventilator support.	F 757	This Plan of Correction constitutes the facilities allegation of compliance for the deficiencies citied in the CMA-2567 . The statement made in the plan of Corrections are not admission to and do not indicate an agreement with alleged deficiencies. This Plan of Correction is written and executed as to remain in compliance with all Federal and State regulations such that all alleged deficiencies cited have been or will be corrected by the date (s) indicated. Response to this statement of Delicense does not constitute an admission that any deficiency is accurate. Resident #145 continued to receive Vancomycin intravenously after the facility drew a trough level on 2/10/20 with elevated levels reported to the facility on the laboratory portal on 2/10/20 according to the laboratory and noted by the Director	

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F 757	Continued From page 48 Immediate Jeopardy began on 2/10/2020, when the facility failed to implement measures to address Resident #145's critical Vancomycin Level and continued to administer the resident's Vancomycin until 2/19/2020. The Immediate Jeopardy was removed on 2/28/2020 when the facility provided and implemented a credible allegation of immediate jeopardy removal. The facility remained out of compliance at a lower scope and severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems were put into place are effective. Findings included: Resident #145 was admitted to the facility on 2/6/2020 with diagnoses of metabolic encephalopathy, osteomyelitis, sepsis, diabetes and stage III chronic kidney disease. A physician's order dated 2/6/2020 stated, "Vancomycin Hydrochloride Injection solution reconstituted 1 gram intravenously two times a day for Methicillin Resistant Staphylococcus Aureus (MRSA) until 3/2/2020" by the Primary Physician. A Care Plan for Resident #145 dated 2/6/2020 specified, he had a diagnosis of osteomyelitis related to Methicillin Resistant Staphylococcus Aureus (MRSA) and required intravenous antibiotic therapy. The Care Plan also stated Resident #145's laboratory and diagnostic work should be obtained and monitored as ordered. Resident #145's February 2020 Medication Administration Record noted from 2/6/2020 to 2/18/2020 the resident received Vancomycin	F 757	of Nursing (DON) on 2/11/20 through the laboratory portal. The facility began having scattered problems with phone transmission on 2/10/20 but with a server reset, it appeared that faxes were being received and phones were working. On the evening of 2/11/20 the DON realized that no laboratory results had been received by fax on that day, 2/11/20, and DON opened the lab portal on the computer to pull all results for the day and identified the critical lab alert. In checking, the laboratory reported that multiple attempts were made to reach the facility on 2/10/20 and were unsuccessful. Neither realized that fax reports were also not reaching the facility. The DON pulled the critical alert from the laboratory portal, late in the day on 2/11/20 and due to the time of day, the DON did not call the Infectious Diseases office who had ordered the Vancomycin trough until the morning or 2/12/20. When the DON attempted to reach the Infectious Disease practice on 2/12/20 to report the result, the DON was unable to reach a person and left a message on the Nurse Line providing the name of resident #145, the resident□s date of birth, the critical lab value and informed them that the phones and faxes were not working consistently in the facility at that moment and asked that they contact the Director of Nursing, (DON) on the DON□s cell phone to give orders. When the DON had not received a response from Infectious Disease physician by 2/13, DON again contacted the Infectious Disease office and left a	

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Hydrochloride Injection Solution Reconstituted 1 gram two times a day for Methicillin Resistant Staphylococcus Aureus (MRSA).

A Progress Note dated 2/7/2020, written by the Nurse Practitioner, stated Resident #145 was seen for new admission to the facility. The progress note also stated Resident #145 was receiving Vancomycin intravenously until 3/2/2020 and was being followed by the Infectious Disease Clinic. The progress note also specified the resident's laboratory results and dosing of the Vancomycin would be done by the pharmacy.

A physician's order dated 2/10/2020 specified Vancomycin Trough (a blood test to check the Vancomycin level in Resident #145's blood) was to be administered 30 minutes prior to Vancomycin administration every Monday and the results were be faxed to the Infectious Disease Physician at the Infectious Disease Center within 24 hours of drawing specimen.

A Vancomycin Trough collected on 2/10/2020 and marked reported by the laboratory on 2/10/2020 revealed Resident #145's Vancomycin level was critical at 41.52 micrograms/milliliter (mcg/ml) with a normal reference range of 10.00 to 20.00 mcg/ml.

Resident #145's medical record revealed on 2/10/2020 there was no indication the Infectious Disease Physician at the Infectious Disease Center or the resident's physician was notified of the resident's critically high Vancomycin level of 41.52 mcg/ml. Additionally, there was no physician's order written on 2/10/2020 to stop the administration of the resident's Vancomycin twice a day based on the resident's critically high

second message on the Nurse Line. The Infectious Disease office nurse claims to have attempted to call the facility on 2/12 and 2/13 repeatedly but was unable to reach the facility by phone. The Infectious Disease nurse did not attempt to reach the DON on the DON□s cell phone as directed on the two messages left.
According to the DON the Nurse Practitioner (NP) was made aware of the critical lab on 2/12/20 while in the facility and instructed the Nurse to notify Infectious Diseases. The NP has denied knowing about the critical lab.
The Vancomycin trough was again scheduled for 2/17/20 but as the 2/10/20 result remained unresolved, the Nurse did not add the Vancomycin trough to the laboratory requisition or draw it thirty minutes prior to the next dose as would be required for a trough. According to the record, the DON notified the Nurse Practitioner on 2/18/20 about the critical value of 2/10/20 and the order was placed to discontinue the Vancomycin until the Infectious Disease practitioner could be reached. Infectious Diseases and the DON finally made contact on 2/20/20 to discuss the critical lab result of 2/10/20 resulting in an order to send send Resident #145 to the hospital by the Infectious Disease office.
The DON failed to make contact with the Nurse Practitioner or the Medical Director for instructions when the DON was unable to contact the Infectious Disease doctor□s office and continued to administer the Vancomycin resulting in a toxic level of Vancomycin in the Resident

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F 757	Continued From page 50 Vancomycin level. Review of the Pharmacist's Medication Review dated 2/12/2020 for Resident #145 revealed the laboratory results were reviewed and no irregularities were found. The pharmacy review did not mention the resident's 2/10/2020 critical Vancomycin level of 41.52 mcg/ml. A Progress Note dated 2/12/2020, written by the Nurse Practitioner (NP), specified Resident #145 was receiving Vancomycin intravenously and the Infectious Disease Clinic and Pharmacy were monitoring the dose. The NP progress note did not mention the resident's 2/10/2020 critical Vancomycin level of 41.52 mcg/ml. An Admission Minimum Data Set (MDS) Assessment dated 2/12/2020 revealed Resident #145 was cognitive intact. The Admission MDS Assessment further revealed Resident #145 was on antibiotics and had diagnosis of septicemia. A Progress Note dated 2/14/2020, written by the Nurse Practitioner, specified Resident #145 was receiving Vancomycin. The progress note also specified Infectious Disease was monitoring the resident's antibiotic therapy. The NP progress note did not mention the resident's 2/10/2020 critical Vancomycin level of 41.52 mcg/ml. On 2/17/2020 (a Monday) a Vancomycin Trough was not drawn for Resident #145 on this Monday as ordered on 2/10/2020. A Progress Note dated 2/17/2020, written by the Nurse Practitioner, stated Resident #145 was seen for a 10-day post admission follow-up. The progress note further specified Resident #145	F 757	#145. Resident #145 was hospitalized on 2/20/20 with elevated Vancomycin levels and remains hospitalized as of 2/27/20. Any resident who is administered medications where doses and administration depend on blood levels, (ie: Coumadin and Levothyroxine) would have the potential to be affected by a failure to properly monitor those levels. To assure no other residents were affected by the same circumstances of telephone and fax issues and the decisions made around managing critical labs, on 2/26/20 and 2/27/20 the Staff Development Coordinator, DON and Regional Director of Clinical Services reconciled the last thirty (30) days of lab listings from Point Click Care, compared these to the laboratory requisitions used to draw laboratory specimens and examined the results received. No other laboratory orders had been missed and no other critical labs had not been reported. here are no other residents being administered antibiotics that require laboratory monitoring by intravenous methods at this time Specify the Action the Facility will take to alter the process or system failure to Prevent a Serious Outcome from occurring or reoccurring and when the Action will be complete. The facility had experienced telephone and fax transmission inconsistencies and had contacted the telephone service provider (Jetway) and the Information Technology firm on 2/10/20 to forward calls to the facility cell phone number which was held by the Receptionist to	

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was tolerating intravenous Vancomycin and the Vancomycin dose was managed by the infectious disease clinic and pharmacy. The NP progress note did not mention the resident's 2/10/2020 critical Vancomycin level of 41.52 mcg/ml.

On 2/19/20 a physician's order was written by the Nurse Practitioner to hold the resident's Vancomycin.

A Nurse's Note dated 2/20/2020 at 12:45 pm written by Nurse #3, stated Resident #145 was sent to the Emergency Room for abnormal laboratory findings after Director of Nursing spoke with the Infectious Disease Clinic.

The hospital History and Physical dated 2/20/2020, stated the resident was discharged from the hospital to the facility on 2/6/2020 with a Creatinine of 1.47milligrams/deciliter but returned to the hospital on 2/20/2020 with a Creatinine of 7.07 milligrams/deciliter (a normal reference range for Creatinine Level is 0.60 to 1.30 milligrams/deciliter). The History and Physical also stated Nephrology was consulted and Resident #145's acute renal failure was possibly related to Vancomycin therapy, diarrhea, and hypotension. Resident #145's Vancomycin Trough level was 87.3 mcg/ml on 2/20/2020 when he returned to the hospital (a normal reference range for a Vancomycin Trough level is 10.00 to 20.00 mcg/ml).

An interview was conducted on 2/25/2020 at 3:42 pm with the Director of Nursing (DON). The DON stated the resident's 2/10/2020 Vancomycin Trough Level that was elevated was not reported to the Infectious Disease Center until 2/12/2020 when she left a voice message for the Infectious

answer all incoming calls and faxes were forwarded to the email address of the Business Office Manager in effort to resolve the issue. The initial recommendation by Information Technology to reset the server appeared to correct the problem which gave the facility a sense of confidence that the communication issues were resolved.
On 2/11/20 the DON realized that the problem was occurring again, the telephone service provider (Jetway) and the IT firm were again notified. The problem was fully resolved on 2/17/20 and telephone and fax service has been consistent since that time.

The Administrator□s and the Director of Nursing□s cell phone numbers as well as the facility cell phone number have been provided to the laboratory, pharmacy, X-ray, Infectious Disease and Medical Director in order to provide a back up number for emergency contact in the event of if these providers are unable to reach the facility.
As the DON was responsible for failing to notify the Medical Director when the DON was unable to reach the prescribing physician immediately (within two hours of receiving the Critical value), the DON was re-educated by the Regional Director of Clinical Services on both 2/26 and 2/27 with an emphasis on the urgency of reporting Critical lab values and changes in condition to the physician and the Medical Director if unable to reach the physician. The DON received a verbal counseling session that required a

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Disease Nurse. The DON stated her voice message specified the resident's Vancomycin Trough level was critically high at 41.52 mcg/ml. The DON also specified on 2/20/20 Resident #145 was transferred to the hospital due to a high Vancomycin Trough Level and poor kidney function.

An interview was conducted with the Infectious Disease (ID) Nurse on 2/27/2020 at 8:58 am. The ID nurse stated she received a voice mail message from the facility's DON on 2/12/2020 which stated Resident #145's Vancomycin Trough Level was 41.52 mcg/ml. The ID Nurse stated she immediately called the facility on 2/12/2020, but no one answered the facility's phone. She stated she also called the facility several times on 2/13/2020, but could not reach anyone. She further stated on 2/18/2020 she called the facility and spoke to Nurse #6 and asked to speak to the nurse who was caring for Resident #145. The Infectious Disease Nurse stated Nurse #6 told her she could not reach anyone on that side of the facility and would ask the Director of Nursing to call her back. The Infectious Disease Nurse stated she called the facility again on Wednesday (2/19/2020) and spoke to the Director of Nursing. She said the DON informed her when the facility did not hear back from the Infectious Disease Clinic on 2/12/2020, after she left the voice message about the resident's critically high Vancomycin level, the facility did not stop the administration of the resident's vancomycin medication until 2/19/2020. The Infectious Disease Nurse further stated after the DON informed her that the resident's Vancomycin medication was not discontinued on 2/12/2020 she told the Director of Nursing that Resident #145 should be sent immediately to the

signature acknowledging the failure counseled on by the Regional Director of Clinical Services on 2/27/20.
On 2/26/20 the Administrator, DON and SDC began in-servicing all nurses on the importance of 1) informing the physician about any significant changes in condition. 2) the process for assuring order listings for lab draws are correctly entered in the lab draw book for the following morning, 3) the process for assuring that blood is drawn as ordered, 4) the process for confirming that results are received.
In-services of nurses include a clarified process by which the nurse will immediately contact the prescribing physician to report any abnormal lab values for medication monitoring. A message left must be returned within two hours or the nurse will call the facility□s Medical Director to advise of the abnormal value and get instructions for managing the elevated level. The nurse is instructed not to continue to administer the medication associated with the elevated blood level until the nurse has received clear instructions from the physician.
In-servicing also stressed that nurses must inform the medical director about any significant changes in condition if unable to reach the attending or consulting physician who may have initially ordered medication or treatment and prior to administering any such medication or treatment. CNAs were in-serviced on the importance of reporting any changes in condition to the Nurse in charge immediately both in writing/verbally

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F 757	Continued From page 53 Emergency Room due to renal failure. An interview with the Infectious Disease Physician on 2/27/2020 at 9:19 am revealed with a Vancomycin Trough level of over 20 mcg/ml the resident's Vancomycin should have been stopped. The Physician stated continuing to administer the resident's Vancomycin at the same dose would have caused Resident #145's renal failure. An interview with the Nurse Practitioner on 2/27/2020 at 9:50 am revealed he stated the Infectious Disease Clinic was following Resident #145's Vancomycin and he was not aware of the Vancomycin trough being elevated on 2/10/2020 until his visit on 2/17/2020. The NP stated on 2/17/2020 he gave an order to stop the Vancomycin and to notify the infectious Disease Clinic of the elevated levels, but he did not remember which nurse he spoke to regarding the order. The Nurse Practitioner stated he did not know why an order was not written to stop the resident's Vancomycin until 2/19/2020. An interview with the resident's Primary Physician on 2/27/2020 at 10:22 am revealed he saw Resident #145 on 2/10/2020, but was not aware of the resident's elevated Vancomycin Trough Level. He stated if staff had notified him of the resident's critically high Vancomycin he would have stopped the Vancomycin. An interview was conducted with The Laboratory Supervisor on 2/27/2020 at 1:45 pm. The lab supervisor stated Resident #145's 2/10/2020 Vancomycin Trough level was processed on 2/10/2020 at 5:15 pm and were released on the laboratory website at 6:19 pm on 2/10/2020. The Laboratory Supervisor stated the facility had	F 757	through the Stop and Watch ticket as well as placing a Nurse Alert on the Point of Care wall kiosk system in which CNAs document care. Staff who was not assigned to work on 2/26 or 2/27 was contacted by telephone and informed of the requirement. Each will also be in-serviced in person prior to working on the floor. The Administrator and the Director of Nursing completed the in-service of all employed nurses and CNAs on 2/27/20. In addition, the instruction has been added to the Nurse and CNA Orientation programs to assure that future nursing staff fully understands both the importance and the process for reporting changes in condition, abnormal labs or other diagnostic findings immediately to the physician or NP. The facility does not contract with any outside staffing agencies or use agency or contract staff. If, in the future this occurs, the nursing supervisor for that shift will be responsible for providing written instruction to that agency staff person. To assure that the complication of the phones and faxes inconsistency does not reoccur, the Administrator contacted the Information Technology service who worked with the telephone provider to resolve the issues. Telephone and fax services are working dependably as of 2/17/20. The back up cellular service has been established as above as an extra measure in assuring that someone from the facility who is in a position of responsibility can be reached at all times. Immediate Jeopardy is removed as of	

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F 757	Continued From page 54	F 757	2/28/20.	

access to the results at that time. The Laboratory Supervisor stated once a critical laboratory level is noted they immediately call the Nurse at the facility. She stated the Laboratory called the facility numerous times but could not get through because no one was answering the facility's phone. The Laboratory Supervisor also stated on 2/10/20 the Laboratory faxed Resident #145's lab results to the facility as well.

A second interview with the Director of Nursing was conducted on 2/27/2020 at 2:00 pm. The DON revealed she did not know why Resident #145's Vancomycin Trough was not drawn on 2/17/2020. The Director of Nursing stated the normal procedure regarding laboratory tests is the orders are entered into the computer by the Physician and Nurse Practitioner and the evening shift supervisor prints the order listing report and fills out a laboratory request sheet for each laboratory test ordered. The laboratory request sheets are placed in the lab book for the phlebotomist. The phlebotomist draws the laboratory specimens each morning. The Director of Nursing stated the laboratory results are printed to the fax machine in the medication room. She stated if the fax machine is not working the supervisor or unit manager prints the results from the laboratory site on the computer. The Director of Nursing stated she was responsible for printing the laboratory results if the fax machine was not working, since she was also the Unit Manager for the unit. The Director of Nursing stated the facility's telephones were not working properly from 2/10/2020 to 2/17/2020 and Resident #145's 2/10/2020 lab results did not print to the fax machine. She stated she did not retrieve the results of the resident's 2/10/2020 Vancomycin Trough drawn until 2/12/2020, but

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CURIS AT CONCORD NURSING & REHABILITATION CENTER	515 LAKE CONCORD ROAD NE CONCORD, NC 28025

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confirmed the resident's lab results were accessible on the laboratory's website. The Director of Nursing stated she gave the results of Resident #145's Vancomycin Trough drawn on 2/10/2020 to the Nurse Practitioner on 2/12/2020 when she printed the results from the laboratory website on the computer and the NP did not say to hold the resident's Vancomycin at that time.

An interview with the facility's Consultant Pharmacist on 2/28/2020 at 10:48 am revealed she reviewed Resident #145's medications on 2/12/2020, but was not informed the resident had a critical Vancomycin Trough of 41.52 mcg/ml on 2/10/2020. The Pharmacist stated she was aware Resident #145 was on Vancomycin, but the pharmacy was not involved in dosing Resident #145's Vancomycin since the Infectious Disease Clinic was following him.

An interview with the facility's Medical Director on 2/28/2020 at 11:32 am revealed he was not notified of the Resident #145's 2/10/2020 critical Vancomycin Trough drawn of 41.52 mcg/ml. The Medical Director stated he would have stopped the Vancomycin immediately if he had been notified of the resident's critical level and continuing to administer the Vancomycin could have led to the resident's renal failure. The Medical Director also stated the Infectious Disease Clinic was managing the dosing of Resident #145's Vancomycin and they were notified by voicemail of the laboratory result.

An interview was conducted on 2/28/2020 at 11:57 am with a representative of the phone company the facility utilizes. The representative stated the facility called on 2/10/2020 to report they were not receiving calls into the facility and

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could not call out of the facility. The Representative stated the phones were repaired on 2/17/2020.

An interview with the Administrator was conducted on 2/28/2020 at 2:42 pm. The Administrator stated the nursing staff should have reported the resident's critical Vancomycin laboratory result to the Medical Director on 2/12/2020 when they did not hear back from the Infectious Disease Clinic.

A palliative care consult from the hospital dated 2/27/2020 specified Resident #145 had a ventricular fibrillation arrest on 2/26/2020 and currently required ventilator support. The consult further revealed Resident #145 was being evaluated for palliative care and family members were made aware of his condition.

The Administrator was notified of immediate jeopardy on 2/27/2020 at 4:11 pm. On 2/28/2020 the facility provided the following Credible Allegation of Immediate Jeopardy Removal:

F757 Credible Allegation of Immediate Jeopardy removal
Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance
Resident #145 continued to receive Vancomycin intravenously after the facility drew a trough level on 2/10/20 with elevated levels reported to the facility on the laboratory portal on 2/10/20 according to the laboratory and noted by the Director of Nursing (DON) on 2/11/20 through the laboratory portal.
The facility began having scattered problems with phone transmission on 2/10/20 but with a server

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reset, it appeared that faxes were being received and phones were working. On the evening of 2/11/20 the DON realized that no laboratory results had been received by fax on that day, 2/11/20, and DON opened the lab portal on the computer to pull all results for the day and identified the critical lab alert. In checking, the laboratory reported that multiple attempts were made to reach the facility on 2/10/20 and were unsuccessful. Neither realized that fax reports were also not reaching the facility.

The DON pulled the critical alert from the laboratory portal, late in the day on 2/11/20 and due to the time of day, the DON did not call the Infectious Diseases office who had ordered the Vancomycin trough until the morning or 2/12/20. When the DON attempted to reach the Infectious Disease practice on 2/12/20 to report the result, the DON was unable to reach a person and left a message on the "Nurse Line" providing the name of resident #145, the resident's date of birth, the critical lab value and informed them that the phones and faxes were not working consistently in the facility at that moment and asked that they contact the Director of Nursing, (DON) on the DON's cell phone to give orders. When the DON had not received a response from Infectious Disease physician by 2/13, DON again contacted the Infectious Disease office and left a second message on the "Nurse Line". The Infectious Disease office nurse claims to have attempted to call the facility on 2/12 and 2/13 repeatedly but was unable to reach the facility by phone. The Infectious Disease nurse did not attempt to reach the DON on the DON's cell phone as directed on the two messages left. According to the DON the Nurse Practitioner (NP) was made aware of the critical lab on 2/12/20 while in the facility and

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instructed the Nurse to notify Infectious Diseases. The NP has denied knowing about the critical lab. The Vancomycin trough was again scheduled for 2/17/20 but as the 2/10/20 result remained unresolved, the Nurse did not add the Vancomycin trough to the laboratory requisition or draw it thirty minutes prior to the next dose as would be required for a trough. According to the record, the DON notified the Nurse Practitioner on 2/18/20 about the critical value of 2/10/20 and the order was placed to discontinue the Vancomycin until the Infectious Disease practitioner could be reached. Infectious Diseases and the DON finally made contact on 2/20/20 to discuss the critical lab result of 2/10/20 resulting in an order to send send Resident #145 to the hospital by the Infectious Disease office.

The DON failed to make contact with the Nurse Practitioner or the Medical Director for instructions when the DON was unable to contact the Infectious Disease doctor's office and continued to administer the Vancomycin resulting in a toxic level of Vancomycin in the Resident #145. Resident #145 was hospitalized on 2/20/20 with elevated Vancomycin levels and remains hospitalized as of 2/27/20.

Any resident who is administered medications where doses and administration depend on blood levels would have the potential to be affected by a failure to properly monitor those levels. To assure no other residents were affected by the same circumstances of telephone and fax issues and the decisions made around managing critical labs, on 2/26/20 and 2/27/20 the Staff Development Coordinator, DON and Regional Director of Clinical Services reconciled the last thirty (30) days of lab listings from Point Click

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Care, compared these to the laboratory requisitions used to draw laboratory specimens and examined the results received. No other laboratory orders had been missed and no other critical labs had not been reported. There are no other residents being administered antibiotics that require laboratory monitoring by intravenous methods at this time.

Specify the Action the Facility will take to alter the process or system failure to Prevent a Serious Outcome from occurring or reoccurring and when the Action will be complete.
The facility had experienced telephone and fax transmission inconsistencies and had contacted the telephone service provider and the Information Technology firm on 2/10/20 to forward calls to the facility cell phone number which was held by the Receptionist to answer all incoming calls and faxes were forwarded to the email address of the Business Office Manager in effort to resolve the issue. The initial recommendation by Information Technology to reset the server appeared to correct the problem which gave the facility a sense of confidence that the communication issues were resolved. On 2/11/20 the DON realized that the problem was occurring again, the telephone service provider and the IT firm were again notified. The problem was fully resolved on 2/17/20 and telephone and fax service has been consistent since that time.

The Administrator's and the Director of Nursing's cell phone numbers as well as the facility cell phone number have been provided to the laboratory, pharmacy, Xray and Medical Director in order to provide a back up number for emergency contact in the event of if these providers are unable to reach the facility effective

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F 757	Continued From page 60 2/28/20. As the DON was responsible for failing to notify the Medical Director when the DON was unable to reach the prescribing physician immediately (within two hours of receiving the Critical value), the DON was re-educated by the Regional Director of Clinical Services on both 2/26 and 2/27 with an emphasis on the urgency of reporting Critical lab values and changes in condition to the physician and the Medical Director if unable to reach the physician. The DON received a verbal counseling session that required a signature acknowledging the failure counseled on by the Regional Director of Clinical Services on 2/27/20. On 2/26/20 the Administrator, DON and SDC began in-servicing all nurses on the importance of 1) informing the physician about any significant changes in condition. 2) the process for assuring order listings for lab draws are correctly entered in the lab draw book for the following morning, 3) the process for assuring that blood is drawn as ordered, 4) the process for confirming that results are received. In-services of nurses include a clarified process by which the nurse will immediately contact the prescribing physician to report any abnormal lab values for medication monitoring. A message left must be returned within two hours or the nurse will call the facility's Medical Director to advise of the abnormal value and get instructions for managing the elevated level. The nurse is instructed not to continue to administer the medication associated with the elevated blood level until the nurse has received clear instructions from the physician. In-servicing also stressed that nurses must inform the medical director about any significant changes in condition if unable to reach the	F 757		

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attending or consulting physician who may have initially ordered medication or treatment and prior to administering any such medication or treatment. CNAs were in-serviced on the importance of reporting any changes in condition to the Nurse in charge immediately both in writing/verbally through the Stop and Watch ticket as well as placing a Nurse Alert on the Point of Care wall kiosk system in which CNAs document care. Staff who was not assigned to work on 2/26 or 2/27 was contacted by telephone and informed of the requirement. Each will also be in-serviced in person prior to working on the floor.
The Administrator and the Director of Nursing completed the in-service of all employed nurses and CNAs on 2/27/20. In addition, the instruction has been added to the Nurse and CNA Orientation programs to assure that future nursing staff fully understands both the importance and the process for reporting changes in condition, abnormal labs or other diagnostic findings immediately to the physician or NP. The facility does not contract with any outside staffing agencies or use agency or contract staff. If, in the future this occurs, the nursing supervisor for that shift will be responsible for providing written instruction to that agency staff person.
To assure that the complication of the phones and faxes inconsistency does not reoccur, the Administrator contacted the Information Technology service who worked with the telephone provider to resolve the issues. Telephone and fax services are working dependably as of 2/17/20. The back up cellular service has been established as above as an extra measure in assuring that someone from the facility who is in a position of responsibility can be reached at all times.

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Immediate Jeopardy is removed as of 2/28/20.

Validation of the facility's Credible Allegation of Immediate Jeopardy Removal:
A review on 2/28/2020 of the plan to ensure those affected by the deficient practice revealed the facility had investigated the incident. The facility reconciled the last thirty days of resident with laboratory test and compared them to the laboratory requisitions used to draw laboratory specimens to ensure no other residents were affected. The facility found that no other critical laboratory results had not been reported. The Administrator's, Director of Nursing's, and the facility cell phone numbers were provided to the laboratory, pharmacy, x-ray, and Medical Director in order to provide a backup number for emergency contact in the event of these providers not being able to reach the facility effective 2/28/2020. The Director of Nursing was re-educated on the urgency of reporting critical laboratory values to the physician and Medical Director within 2 hours of receiving a critical laboratory value. The facility developed an audit tool to monitor the reporting of critical laboratory values. The nursing staff were in-serviced on the importance of the process for assuring order listings for laboratory draws are correctly entered in the lab draw book; the process for assuring blood is drawn as ordered; and the process for confirming the results are received. The in-servicing also included ensuring the physician is contacted regarding any abnormal laboratory results immediately. Nursing staff from all three shifts were interviewed regarding the in-services and verbalized understanding. The facility will provide the same in-service education to any new nursing employees.

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F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff, and telephone company representative interviews, the facility failed to ensure a working telephone was in place when the phone system is disabled for receiving laboratory results; reporting critical laboratory results; and receiving follow-up calls from the infectious Disease Clinic for 1 of 4 residents reviewed for unnecessary medications, Resident #145. Resident #145 had a critically high Vancomycin level and Infectious Disease Clinic was unable to call into the facility to ensure the resident's Vancomycin was stopped. The facility's failure to put an alternate communication system in place affected all residents in the facility. Findings included: A physician's order dated 2/10/2020 specified Vancomycin Trough (a blood test to check the Vancomycin level in Resident #145's blood) was to be administered 30 minutes prior to Vancomycin administration every Monday and the results were be faxed to the Infectious Disease Physician at the Infectious Disease Center within 24 hours of drawing specimen. A Vancomycin Trough collected on 2/10/2020 and marked reported by the laboratory on 2/10/2020 revealed Resident #145's Vancomycin level was	F 835	This Plan of Correction constitutes the facilities allegation of compliance for the deficiencies citied in the CMA-2567 . The statement made in the plan of Corrections are not admission to and do not indicate an agreement with alleged deficiencies. This Plan of Correction is written and executed as to remain in compliance with all Federal and State regulations such that all alleged deficiencies cited have been or will be corrected by the date (s) indicated. Response to this statement of Delicense does not constitute an admission that any deficiency is accurate. No residents were named in the citation The facility had experienced telephone and fax transmission inconsistencies and had contacted the telephone service provider (Jetway) and the Information Technology firm on 2/10/20 to forward calls to the facility cell phone number which was held by the Receptionist to answer all incoming calls and faxes were forwarded to the email address of the Business Office Manager in effort to resolve the issue. The initial recommendation by Information Technology to reset the server appeared	3/23/20

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F 835	Continued From page 64 critical at 41.52 micrograms/milliliter (mcg/ml) with a normal reference range of 10.00 to 20.00 mcg/ml. An interview was conducted on 2/25/2020 at 3:42 pm with the Director of Nursing (DON). The DON stated the critically high Vancomycin Trough level was not reported to the Infectious Disease Center until 2/12/2020 when she left a voice message for the Infectious Disease Nurse. She stated the telephone lines were down in the facility and she did not realize the fax had not been working since 2/10/2020 and the laboratory results had not come through the fax as normal. The DON stated she ran the laboratory results from the laboratory's computer website which the facility had access to but did not run them until 2/12/2020. During an interview with the Infectious Disease (ID) Nurse on 2/27/2020 at 8:58 am she stated she received a voice mail message from the facility's DON on 2/12/2020 that indicated Resident #145's Vancomycin Trough Level was 41.52. The ID Nurse stated she immediately called back to the facility several times on 2/12/2020 and also called several times on 2/13/2020 but could not reach anyone. She stated on 2/18/2020 she called the facility and spoke to Nurse #6 and asked to speak to the nurse that was taking care of Resident #145. The ID Nurse stated Nurse #6 told her she could not reach anyone on that side of the facility and she would ask the DON to call her back. The ID Nurse stated she called the facility again on 2/19/2020 and spoke with the Director of Nursing. The ID Nurse sated the DON informed her when the facility did not hear back form the Infectious Disease Clinic on 2/12/2020, when the DON left	F 835	to correct the problem which gave the facility a sense of confidence that the communication issues were resolved. On 2/11/20 the DON realized that the problem was occurring again, the telephone service provider (Jetway) and the IT firm were again notified. The problem was fully resolved on 2/17/20 and telephone and fax service has been consistent since that time. The Administrator□s and the Director of Nursing□s cell phone numbers as well as the facility cell phone number have been provided to the laboratory, pharmacy, Xray and Medical Director in order to provide a backup number for emergency contact in the event of if these providers are unable to reach the facility effective 2/28/20. The maintenance director or maintenance assistant will test weekly 5 times a week for 4 weeks then 3 times a times for 4 weeks then weekly times 1 month or until corrective action is achieved. Findings will be reviewed with the administrator weekly any issues will be addressed immediately. Results will be discussed and addressed as needed during the facility monthly Quality Assessment and Performance improvement meeting.	

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the voice message about the critically high Vancomycin Trough Level, the facility did not stop the administration of the residents intravenous vancomycin medication until 2/19/2020.

An interview was conducted with the Laboratory Supervisor on 2/27/2020 at 1:45 pm. The supervisor stated Resident #145's 2/10/2020 Vancomycin Trough Level was processed on 2/10/2020 at 5:15 pm and the results were released on the laboratory's website at that time for viewing by the facility. The Laboratory Supervisor stated the Laboratory called the facility numerous times but could not get through because no one was answering the facility's phone. The Laboratory Supervisor stated the Laboratory had also faced Resident #145's lab results to the facility on 2/10/2020.
During a second interview with the DON on 2/27/2020 at 2:00 pm she stated she the normal procedure regarding laboratory test is the laboratory faxes the printed results to the fax machine in the medication room. The DON stated she did not realize Resident #145's Vancomycin Trough Level was not faxed until 2/12/2020 and then she printed the results from the laboratory website. The DON stated the facility's telephone lines were not working properly from 2/10/202 to 2/17/2020 so the fax machine was not working.

An interview with the phone company representative on 2/28/2020 at 11:57 am revealed facility called on 2/10/2020 to report the facility was not able to receive calls in the facility or call out of the facility. The representative stated the phones were repaired on 2/17/2020.

During an interview with the Administrator on

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F 835	Continued From page 66 2/27/2020 at 2:42 pm she stated the facility had notified the phones company of the issue with the phones on 2/10/2020 but the phones were not repaired until 2/17/2020.	F 835		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse,	F 842		3/23/20

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	345130	A. BUILDING _____ B. WING _____	C 02/28/2020

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CURIS AT CONCORD NURSING & REHABILITATION CENTER	515 LAKE CONCORD ROAD NE CONCORD, NC 28025

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F 842	Continued From page 67 neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to record administered medications in the Electronic Medication Administration Record (EMAR) for one of five residents (Resident #21) observed for	F 842	This Plan of Correction constitutes the facilities allegation of compliance for the deficiencies citied in the CMA-2567 . The statement made in the plan of Corrections are not admission to and do not indicate	

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F 842	Continued From page 68 medication administration. Findings included: During a medication pass, which started on 2/24/20 at 4:05 PM, Resident #21 requested pain medication from Nurse #2 and stated she had received the last dose of pain medication in the morning. When Nurse #2 checked Resident #21 ' s EMAR she stated the resident was prescribed to receive one-half tablet of hydrocodone 5 milligrams (mg)/acetaminophen 325 mg (pain pill) every 8 hours, as needed, for pain. However, she stated when she checked the EMAR there was no record the resident had received the pain pill at all during the whole day. The nurse checked the medication monitoring/control record or narcotics book stated she saw where Nurse #5 had signed out for one-half pain pill earlier in the day at 12:30 PM and she believed the nurse had not signed off the pain pill as having been administered in the EMAR. The resident stated if she could not have the pain pill, she would like to have acetaminophen for her pain. Nurse #2 was then observed administering 1 650mg acetaminophen pill to the resident. During a review of Resident #21 ' s February EMAR conducted on 2/25/20 it was observed there was no record for the administration of the one-half tablet of hydrocodone 5 mg/acetaminophen 325 mg (pain pill) nor the 650 mg acetaminophen on 2/24/20. An interview was conducted on 2/25/20 at 11:15 AM with Nurse #5 and she stated she should have documented in the EMAR she had administered the one-half tablet of hydrocodone 5 milligrams (mg)/acetaminophen 325 (mg) (pain	F 842	an agreement with alleged deficiencies. This Plan of Correction is written and executed as to remain in compliance with all Federal and State regulations such that all alleged deficiencies cited have been or will be corrected by the date (s) indicated. Response to this statement of Delicense does not constitute an admission that any deficiency is accurate. Nurse #5 initiated a late entry on the Electronic Medication Administration Record.(EMAR) that reflects the administration of medication given to resident #145. All residents requiring a PRN (as Needed) medication have the potential to be affected. As a result, an audit on all residents on PRN medications will be conducted to ensure that proper documentation is completed post administration on 3-21-2020. All licensed nursing staff will be educated on proper documentation regarding PRN administration 3-20-2020. The Director of Nursing Services, or designee, will audit all potentially affected residents PRN narcotic records for proper documentation on the EMAR 5 times a week x 4 weeks, then 3 times a week x 4, then weekly x 1 month or until corrective action is achieved. Findings will be reviewed with the administrator weekly. Results will be discussed and addressed as needed during the facility□s monthly Quality	

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F 842	Continued From page 69 pill) on 2/24/20 to Resident #21. She stated she had not because it had gotten really busy and she had received a transfer resident from another hall in the facility. The Director of Nursing (DON) was interviewed on 2/25/20 at 11:20 AM and she stated when a medication is administered it was her expectation for the medication to be signed off in the resident ' s EMAR and if the medication is a narcotic it was her expectation as well it should be signed of in the narcotics book. Nurse # 2 stated during an interview conducted on 2/25/20 at 4:32 PM she was confident she had documented in Resident #21 ' s EMAR she had administered the acetaminophen. She stated she was confident because there was a certain sequence, she had to go through to save the administration information. The nurse was observed reviewing the EMAR for Resident #21 and stated the information she had entered regarding the administration of the acetaminophen on 2/24/20 had not saved and it was not in the resident ' s EMAR. An interview was conducted on 2/26/20 at 12:39 PM with the facility Administrator. The Administrator revealed her expectation was when a medication was administered it should be documented in the EMAR so there would be an accurate representation of the administration of the medication.	F 842	Assessment and Performance Improvement (QAPI) meeting.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance.	F 867		3/23/20

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F 867	Continued From page 70 §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions the committee put into place following their 4/18/19 recertification and complaint investigation survey. This was for 2 recited deficiencies in the areas of; Failure to complete an admission Minimum Data Set (MDS) assessments within 14 days of the resident's admission date (F-636) and Failure to complete quarterly MDS assessments within 14 days of their Assessment Reference Date (F-638). These deficiencies were cited again during the facility's current recertification and complaint investigation survey of 02/28/20. The continued failure of the facility during two federal surveys of records shows a pattern of the facility's inability to sustain an effective QAA Program. The findings included: This tag is cross referenced to: F636- Based on medical record review and staff interviews, the facility failed to complete an admission assessment within 14 days of the admission date for 1 of 3 residents (Resident #1) reviewed for timely completion of admission Minimum Data Set (MDS) assessments. During the facility's recertification survey of 04/18/19 the facility failed to complete an annual comprehensive Minimum Data Set (MDS) and	F 867	This Plan of Correction constitutes the facilities allegation of compliance for the deficiencies citied in the CMA-2567 . The statement made in the plan of Corrections are not admission to and do not indicate an agreement with alleged deficiencies. This Plan of Correction is written and executed as to remain in compliance with all Federal and State regulations such that all alleged deficiencies cited have been or will be corrected by the date (s) indicated. Response to this statement of Delicense does not constitute an admission that any deficiency is accurate. No residents were named in the citation 2/26/2020 resident #1 Comprehensive Assessment dated 9/30/19 with a completion date of 10/8/19 was reviewed and noted completed late by the Minimum Data Set Nurse. On 3/19/2020, the Minimum Data Assessment Nurse performed Quality Improvement monitoring for all current residents with Comprehensive assessments in progress to identify any late assessments. Any issues identified were addressed. On 3/18/2020, the Minimum Data Set Nurse□s were re-educated by the	

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F 867	Continued From page 71 Care Area Assessments (CAAs) within 14 days of the assessment reference date (ARD) for 1 of 5 residents reviewed for comprehensive MDS completion (Resident #102) and failed to complete a comprehensive admission assessment and CAAs within 14 days of admission for 1 of 3 residents reviewed for admission MDS completion (Resident #57). F638- Based on medical record review and staff interviews, the facility failed to complete a quarterly resident assessment within 14 days of the Assessment Reference Date (ARD) for 2 of 2 residents (Resident #26 and Resident #55) reviewed for timely completion of quarterly Minimum Data Set (MDS) assessments. During the facility's 4/18/19 recertification survey the facility was cited for failure to complete a quarterly Minimum Data Set (MDS) within 14 days of the assessment reference date (ARD) of a quarterly MDS for 1 of 5 residents reviewed for quarterly MDS completion (Resident # 56). During an interview with the Administrator on 2/28/2020 at 2:55 pm she stated the Quality Assurance Committee meets monthly to review progress with the issues the facility is working on. The Administrator stated the facility had strived to improve in all areas but they should have improved in the area identified in the previous survey.	F 867	Regional Minimum Data Set Nurse on timeliness of Comprehensive assessment completion. The Director of Nursing and/or Regional Minimum Data Assessment Nurse will perform Quality Improvement Monitoring of MDS Comprehensive assessments for timeliness of completion by reviewing the In Progress MDS list 3 times per week for four weeks, then twice weekly for two weeks, then one time per week for two months and then one time monthly for three months. Audits will begin 3/23/2020. The Director of Nursing will report on the results of the Quality Monitoring (Audits) to the Quality Assurance Performance Improvement Committee. Findings will be reviewed by QAPI Committee monthly and Quality Monitoring (Audit) updated if changes are needed based on findings. The Quality Assurance Performance Improvement Committee meets monthly and quarterly at a minimum. On 2/26/2020 resident #26 and 55□s Quarterly Assessment dated 10/14/19 and 1/3/2020 with a completion date of 11/3/19 and 2/4/2020 respectively were reviewed and noted completed late by the Minimum Data Set Nurse. On 3/19/2020, the Minimum Data Assessment Nurse performed Quality Improvement monitoring for all current residents with Quarterly assessments in progress to identify any late assessments. Any issues identified were addressed.	

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F 867	Continued From page 72	F 867	On 3/18/2020, the Minimum Data Set Nurse□s were re-educated by the Regional Minimum Data Set Nurse on timeliness of Quarterly assessment completion. The Director of Nursing and/or Regional Minimum Data Assessment Nurse will perform Quality Improvement Monitoring of MDS Quarterly assessments for timeliness of completion by reviewing the In Progress MDS list 3 times per week for four weeks, then twice weekly for two weeks, then one time per week for two months and then one time monthly for three months. Audits will begin 3/23/2020. The Director of Nursing will report on the results of the Quality Monitoring (Audits) to the Quality Assurance Performance Improvement Committee. Findings will be reviewed by QAPI Committee monthly and Quality Monitoring (Audit) updated if changes are needed based on findings. The Quality Assurance Performance Improvement Committee meets monthly and quarterly at a minimum. Date of Compliance is 3/23/2020.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880		3/23/20

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F 880	Continued From page 73	F 880		

comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the

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F 880	Continued From page 74 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to clean and disinfect a shared glucometer (a device used to measure a resident's blood glucose or sugar level) per manufacturer's recommendations after the meter was used on one resident for 1 of 1 sampled resident observed for blood sugar checks (Resident #32). Findings included: The manufacturer's recommendations for cleaning and disinfecting the glucometer utilized by the facility were reviewed. The manufacturer recommended the use of validated disinfectant wipes or other Environment Protection Agency	F 880	This Plan of Correction constitutes the facilities allegation of compliance for the deficiencies citied in the CMA-2567 . The statement made in the plan of Corrections are not admission to and do not indicate an agreement with alleged deficiencies. This Plan of Correction is written and executed as to remain in compliance with all Federal and State regulations such that all alleged deficiencies cited have been or will be corrected by the date (s) indicated. Response to this statement of Delicense does not constitute an admission that any deficiency is accurate. No residents were named in the citation	

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F 880	Continued From page 75 (EPA) registered wipes for disinfecting the meter. An observation was conducted of Nurse #2 on 2/24/20 during her medication pass which started at 4:05 PM. She was observed performing a glucometer check on Resident #32. The nurse removed a glucometer which was stored in the medication cart and brought it into the room of Resident #32. When the nurse entered the room, she stated she remembered each resident who required their blood glucose to be checked because there was a glucometer in a storage container inside of their room. The nurse attempted to do a finger stick blood sugar (FSBS) on the resident with the glucometer inside of the resident ' s room and was unsuccessful due to the machine reading "error." The nurse returned the glucometer, which was in the room, to the storage container. The nurse stated due to the resident having his own assigned glucometer, there was no need to clean it prior to the next use on that resident. The nurse then attempted an FSBS on the resident utilizing the glucometer which she had brought into the resident ' s room and it to read "error." The nurse stated she would check the resident ' s blood sugar later and proceeded to leave the room. Upon leaving the room, the nurse opened the medication cart, opened two alcohol wipe pads and proceeded to wipe down the glucometer with the alcohol wipe pads and placed the glucometer back in the cart. The nurse stated the glucometer had been cleaned and was ready to be used on another resident. The nurse stated she had been trained to clean the glucometer utilizing the alcohol wipe pad. An interview and observation were conducted on 2/24/20 at 5:02 PM with the Director of Nursing	F 880	When the deficient practice was discovered , the nurse was in-serviced immediately on 2/24/2020 on the proper way, as defined by policy to clean the glucometer. The review of the procedure with licensed was completed by the staff development coordinator and or Director of Nursing on 3/23/2020. The staff development coordinator scheduled immediate in-service to review the policy and procedure for the cleaning of the glucometer. Each licenses nurse was schedule for the review. The in-serviced were completed on 3/23/2020 The Director of Nursing Services, or designee, will audit all potentially affected residents that require the use of a glucometer that is not assigned to the resident 5 times a week x 4 weeks, then 3 times a week x 4, then weekly x 1 month or until corrective action is achieved. Findings will be reviewed with the administrator weekly. Results will be discussed and addressed as needed during the facility□s monthly Quality Assessment and Performance Improvement (QAPI) meeting.	

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F 880	Continued From page 76 (DON) and Nurse #2. The DON stated the facility utilized disinfectant wipes for disinfecting glucometers between use. The DON said alcohol wipes would not sufficiently disinfect the glucometer and their policy was to use the disinfectant wipes. The DON proceeded to find the disinfectant wipe on the medication cart and the nurse informed her she had not used the glucometer on any other resident ' s since she had attempted to use it on Resident #32. The DON stated it was her expectation for the glucometer stored in the cart to be cleaned and disinfected between each resident by using the disinfectant wipes. During an interview conducted on 2/26/20 at 12:39 PM the administrator stated it was her expectation for the nurses to follow the facility policy regarding cleaning the glucometers. The administrator further stated the facility had provided training regarding how to clean the glucometers 4 weeks ago because she was aware of how important of a matter disinfecting the glucometers was and she had also instituted each resident having their own glucometers as a matter of infection control.	F 880		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza	F 883		3/23/20

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F 883	Continued From page 77	F 883		

immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 78 immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to provide residents or their representative with education regarding the benefits and potential side effects of the influenza and or the pneumococcal immunization for 4 out of 5 residents reviewed for immunizations (Residents #9, #64, #77, and #290). Findings Included: The facility's untitled policy regarding vaccinations dated January 2019 was reviewed and stated, in part: "The facility will follow the guidance of the Centers for Disease Control, our State and Local Health Departments, when managing an outbreak of respiratory symptoms which closely mirror or test positive for influenza virus." "The facility provides vaccine for all residents with a record being made of prior vaccination, refusal or acceptance with details of date, time, response and lot number of vaccines. The policy did not provide information about educating a resident or the resident's representative regarding the benefits and potential side effects of the immunization; 1. Resident #9 was admitted to the facility on 1/13/2017 with diagnoses to include chronic obstructive pulmonary disease, unspecified, type 2 diabetes mellitus without complications. Resident #9's Minimum Data Set (MDS)	F 883	This Plan of Correction constitutes the facilities allegation of compliance for the deficiencies citied in the CMA-2567 . The statement made in the plan of Corrections are not admission to and do not indicate an agreement with alleged deficiencies. This Plan of Correction is written and executed as to remain in compliance with all Federal and State regulations such that all alleged deficiencies cited have been or will be corrected by the date (s) indicated. Response to this statement of Delicense does not constitute an admission that any deficiency is accurate. No residents were named in the citation Based on Root cause analysis by the Administrative Nurses staff and facility administrator it was determine that there was a lack of clear understanding of the regulatory requirement to provide each resident or legal representative education regarding the potential benefits and risk of Influenza and Pneumococcal immunizations. Immunization Influenza and Pneumococcal education for resident #9, #64, #77 and #290 were giving. On 3-23-2020 all current residents or legal representative were giving education regarding the potential benefits and risk of	

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	345130	A. BUILDING _____ B. WING _____	C 02/28/2020

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F 883	Continued From page 79 admission assessment dated 12/6/19 specified the resident's cognition as being cognitively intact. Resident #9's medical record revealed a signed consent for the influenza immunization on 10/7/19 and administration of the vaccine on 10/8/2019. There was no evidence of education provided to Resident #9. An interview was completed with the Staff Development Coordinator (SDC) on 2/26/20 at 2:51pm who stated, "For the flu vaccines we will get the consent over the phone with the representative's but we do not give out the educational sheet and we do not give out the educational sheet to the residents who are alert and oriented." An interview was completed with the Director of Nursing (DON) on 2/26/2020 at 4:39 pm. She stated, "We do not give out any formal education, we ask if they are allergic to eggs, but basically the residents who are cognitive will tell us if they get the vaccine." An interview was completed with the Administrator on 2/28/20 at 2:45 pm who indicated the education regarding the influenza immunization was to be provided to the resident or representative prior to signing the vaccination consent form. 2. Resident #64 was admitted to the facility on 6/9/2017 with diagnoses to include unspecified Dementia, with behavioral disturbance, anxiety disorder and major depressive disorder. Resident #64's Minimum Data Set (MDS) annual assessment dated 10/17/19 specified the	F 883	influenza and Pneumococcal immunization. Annually each resident or legal representative will be provided education regarding the potential benefits and risk of immunizations between October 1 and March 31. Unless medically contraindicated or refused by the resident or residents□ representative. Residents admitted between October 1 and March 31 who were not previously immunized will receive education and offered immunization upon admission.	

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resident's cognition was moderately impaired. Special Treatments and programs section revealed the last influenza vaccine was completed on 10/03/2018.

Resident #64's medical record revealed no signed consent for the influenza immunization and no evidence of education provided to Resident #64's representative.

An interview with unit manager #1 (UM) on 2/26/20 at 4:41pm stated that Resident #64 had not received any vaccines and were waiting for the representative to sign the vaccination consent once we get in touch with her.

An interview was completed with the Staff Development Coordinator (SDC) on 2/26/20 at 2:51pm who stated, "For the flu vaccines we will get the consent over the phone with the representative ' s but we do not give out the educational sheet and we do not give out the educational sheet to the residents who are alert and oriented."

An interview was completed with the Director of Nursing (DON) on 2/26/2020 at 4:39 pm. She stated, "We do not give out any formal education, we ask if they are allergic to eggs, but basically the residents who are cognitive will tell us if they get the vaccine."

An interview was completed with the Administrator on 2/28/20 at 2:45 pm who indicated the education regarding immunizations was to be provided to the resident or representative prior to signing the vaccination consent form.

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3. Resident #77 was admitted to the facility on 12/11/2019 with diagnoses to include Intracardiac Thrombosis and Type 2 Diabetes mellitus without complications.

Resident #77's medical record showed Resident #77 received the influenza vaccination in the hospital on 10/29/19. Resident #77's representative signed the consent form on 12/12/19 for him to receive the pneumococcal vaccine but there was no evidence of education provided regarding the pneumococcal vaccine or if Resident #77 received it.

Resident #77's Minimum Data Set (MDS) annual assessment dated 12/13/19 specified the resident's cognition was moderately impaired. Special Treatments and programs section of the MDS revealed the pneumococcal vaccine was not offered and the influenza was completed outside of the facility.

An interview with the Staff Development Coordinator (SDC) on 2/26/20 at 2:51 pm who reviewed Resident #77's consent form which was signed on 12/12/19. SDC was not sure as to the status of the pneumococcal vaccine. The consent form was signed upon admission.

An interview with Unit Manager (UM) #1 on 2/26/20 at 4:36 pm stated that she spoke with Resident #77's representative back in January. The representative who was out of town was new to the role and was trying to find out if Resident #77 has already had the pneumococcal vaccine. UM #1 stated, she would follow up with the resident's representative when she returns.

An interview was completed with the Director of

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Nursing (DON) on 2/26/2020 at 4:39 pm. She stated, "We do not give out any formal education, we ask if they are allergic to eggs, but basically the residents who are cognitive will tell us if they get the vaccine."

4. Resident #290 was admitted to the facility on 2/15/2020 with diagnoses to include Type 2 Diabetes mellitus without complications.

Resident #290's medical record revealed a signed consent form for the influenza and pneumococcal vaccine on 2/21/2020 and administration of the influenza and pneumococcal vaccines on 2/25/2020. There was no evidence of education provided to Resident #290 about the benefits and potential side effects of the influenza and the pneumococcal immunization.

Resident #290's Minimum Data Set (MDS) admission assessment dated 2/17/20 specified the resident's cognition was moderately impaired.

An interview was completed with the Staff Development Coordinator (SDC) on 2/26/20 at 2:51pm who stated, "For the flu vaccines we will get the consent over the phone with the representative's but we do not give out the educational sheet and we do not give out the educational sheet to the residents who are alert and oriented."

An interview was completed with the Director of Nursing (DON) on 2/26/2020 at 4:39 pm. She stated, "We do not give out any formal education, we ask if they are allergic to eggs, but basically the residents who are cognitive will tell us if they get the vaccine."

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F 883	Continued From page 83 An interview was completed with the Administrator on 2/28/20 at 2:45 pm who indicated the education regarding the influenza immunization was to be provided to the resident or representative prior to signing the vaccination consent form.	F 883		