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	345142	A. BUILDING _____ B. WING _____	C 02/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PLACE NURSING AND REHABILITATION CENTER	9200 GLENWATER DRIVE CHARLOTTE, NC 28262

(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 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES	F 156		3/8/16

The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.

The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; 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 inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

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 or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal

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

Electronically Signed | 02/26/2016

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F 156	Continued From page 1	F 156		

funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

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This REQUIREMENT is not met as evidenced by:
Based on observation, resident council president (Resident #61) and staff interview, the facility failed to post the number of the complaint intake unit in a manner which could be easily seen by residents.

The findings included:

Review of Resident #61's quarterly Minimum Data Set (MDS) dated 12/10/15 revealed an assessment of moderately impaired cognition. The MDS indicated Resident #61 understood with clear comprehension. The MDS indicted Resident #61's vision was adequate with the ability to see fine detail including regular print in newspapers and books.

Interview with Resident #61 on 02/03/16 at 8:25 AM revealed the facility did not post the complaint intake unit phone number.

Observation of the posted complaint intake unit phone number on 02/03/16 at 9:18 AM with Resident #61 revealed he could not see the complaint intake unit's name and number. Resident #61 wore glasses and used a wheelchair. The complaint intake unit's name and number were included on a listing of state and local government agencies on an 8 ½ inch by 11 inch paper in regular font placed in the upper left corner of a wall mounted board in the hallway next to the lobby. Resident #61 explained he did not realize the complaint number posting existed since he could not see the content of the paper

On 2/1/2016 the Administrator increased the font size of the State Agency information for expressing concerns on the posting located on the 100 hallway near the Administrative hall in order to be accessible for all residents including residents in wheelchairs.

On 2/1/2016 a 100% audit of all state agency postings was completed for Ombudsman contact information and accessibility of the state agency information for all residents including residents in wheelchairs. No negative findings were identified.

On Monday 2/8/2016 the Activities Director held a Resident Council Meeting to ensure residents know the location of the Resident's Rights and Advocacy Agency contact information.

On 2/8/2016 the Administrator added the Ombudsman's contact information to the Admission Packet.

On 2/8/2016 the Administrator educated the Admissions Director that the Ombudsman's contact information must be included in all admissions packets.

Beginning 2/8/2016 the Administrator utilized a monitoring tool titled Postings to monitor for contact information o state

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F 156	Continued From page 3 due to the lettering and number size. During an interview with the Administrator on 02/03/16 at 9:24 AM, the Administrator looked at the posted complaint intake unit's name and number. The Administrator reported the font was too small and could not be easily seen. The administrator reported she would immediately increase the font and place the name and number lower on the board so residents who used wheelchairs could see it.	F 156	agencies and accessibility for residents including residents in wheelchairs. The Postings audit tool will be utilized weekly x 6 weeks by the Administrator. The QI Nurse will present the findings at the next Executive Quality Improvement Committee Meeting. The Executive Quality Improvement Committee will review the results of the audits monthly with recommendations and follow up as needed or appropriate for continued compliance in this area and to determine the need for and/or frequency of continued QI monitoring.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to dress residents in clothing to prevent the residents name from being visible in a locked dementia unit for 1 of 4 residents sampled for dignity (Resident #206). The findings included: Resident #206 was admitted to the facility on 07/22/15 with diagnoses which included cognitive loss/dementia, behavioral symptoms, and psychotropic drug use. A review of the quarterly	F 241	Resident 206 had clothes donned without her name on the outside of her clothes on 2/3/2016. All resident's clothes were audited 2/25/2016 by the Housekeeping Supervisor and the Assistant Housekeeping Supervisors for resident's names written on the outside of their clothes. Any issues were addressed immediately.	3/8/16

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F 241	Continued From page 4 Minimum Data Set (MDS) dated 01/25/16 indicated Resident #206 had severe cognitive impairment and required extensive assistance with activities of daily living (ADLs). Further review of the MDS indicated Resident #206 required extensive assistance with dressing and was occasionally incontinent of bowel and bladder. A review of a care plan dated 01/25/16 indicated a problem/focus for Resident #206 which required assistance/potential to restore or maintain maximum function of self-sufficiency for dressing related to: cognitive deficit. The care plan indicated a goal for Resident #206 to be dressed appropriately with interventions for dressing to be provided with assistance and supervision to ensure clothing is clean and appropriate. On 02/02/16 at 10:21 AM Resident #206 was observed to be visibly soiled setting in a chair in the dining area and a pool of urine was observed in the floor underneath the chair. On 02/02/16 at 10:45 AM Resident #206 was observed to have on dry clothing with her name written boldly in black ink around the neck area on the front portion of her shirt and across the buttocks of her grey pants. On 02/03/16 at 9:40 AM Resident #206 was observed to be visibly soiled setting in a chair in the common living room area. The chair was observed to be wet with a pool of urine underneath the chair. On 02/03/16 at 9:48 AM MDS nurse #2 was observed to take the Resident by her left hand	F 241	All staff retraining was initiated on 2/11/2016 that resident's names are not to be on the outside of their clothes by the Administrator and will be completed on 2/26/2016. All newly hired staff will be trained on resident's name not appearing on the outside of their clothes during orientation. Residents clothes will be audited 5x week x 4 weeks, weekly x8 weeks and monthly x3 using Resident Name appropriately placed audit tool. The results of the completed audit tool will be reviewed weekly by the Administrator and/or the Director of Nursing. the QI Committee will review the audits monthly x 3 to determine the continued need for and frequency of monitoring. Any recommended changes will be discussed and carried out as agreed upon at that time.	

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and escorted her across the living room area to the entrance of the dining area to Nurse Aide (NA) #4. Resident #206's shirt and pants was observed to be visibly soiled front and back from the waist area down. MDS nurse #2 stated to NA #4 "she needs to be changed, she must have spilled water on her." NA #4 was observed to escort Resident #206 into the Resident's room.

On 02/03/16 at 10:00 AM NA #4 was observed to escort Resident #206 out of her room in a clean dry shirt and in the same visibly soiled pants into the facility's "resident bathing area."

On 02/03/16 at 10:15 AM NA #4 was observed to escort Resident #206 to a chair in the dining area in clean dry pants with the Resident's name written in black ink across the buttocks of Resident #206's pants.

On 02/03/16 at 11:20 AM an interview was conducted with NA #4. She stated the MDS Nurse had only communicated to her that Resident #206 was wet and needed assistance. NA #4 confirmed she changed the resident's shirt and had to take Resident #206 to the bathing area to be changed due to the Resident's brief and pants being soaked with urine. NA #4 further confirmed Resident #206's name was written across the buttocks of her pants. NA #4 stated she had not paid any attention to the Resident's name being on the buttocks of her pants and she was unaware of who would have written the Resident's name on the outside of her pants.

On 02/03/16 at 11:23 AM an interview was conducted with Nurse #1. She indicated a resident's name was not supposed to be visible on their clothing and she would have expected

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the resident to have been changed into another pair of pants. Nurse #1 further indicated she was unaware of who would have written the name on the outside of Resident #206's clothing.

On 02/03/16 at 11:30 AM an interview was conducted with MDS Nurse #2. She confirmed she observed Resident #206 to be wet and she had assumed the Resident had spilled water. MDS nurse #2 indicated she had not seen the Resident with a cup of water nor had she observed the Resident drinking water. She further indicated she was unaware the Resident had incontinent episodes and was unaware the chair was wet or that there was urine in the floor. MDS nurse #2 stated should a resident's name be observed on the outside of their clothing the staff would be expected to change the resident clothing.

On 02/03/16 at 5:05 PM an interview was conducted with NA #5. She stated a resident's name was supposed to be written on the inside of their clothing. She further stated she was unaware of who had written Resident #206's name on the outside of her clothing in black ink. NA #5 indicated should a resident's name be observed on the outside of their clothing the staff would be expected to change the resident. NA #5 further indicated she had not paid any attention and was unaware Resident #206's name was boldly written across the buttocks of her pants.

On 02/04/16 at 3:00 PM an interview was conducted with the Director of Nursing (DON). The DON stated her expectation would have been for a resident's clothing to be changed immediately once observed to be soiled or to be changed should the name be visible on the

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F 241	Continued From page 7 outside of a resident's clothing. The DON indicated she was aware of dignity concerns/issues in regards to resident's names being visible on their clothing in the locked unit. She further indicated "this has been a work in progress."	F 241		
F 242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident, family member and staff interviews, and record review, the facility failed to give residents a choice of wake up time for 2 of 5 residents whom the facility's rehabilitation department scheduled for a 5:30 AM session (Resident #76 and #121). The facility also failed to honor a resident's choice to obtain and use a cell phone for 1 of 7 sampled residents (Resident #8). The findings included: 1. Resident #121 was admitted to the facility on 11/30/15 with diagnoses which included dementia. Review of Resident #121's significant change Minimum Data Set dated 12/07/15 revealed an	F 242	Residents #76 and #121 had their choice not to be awaken and gotten up before 5:30 AM honored on 2/5/2016. Resident #8 had her choice to have her own cell phoned honored on 2/4/2016. All residents were interviewed by the Activity and Social Work departments for their preferred time to be awaken and their desire for a cell phone on 2/26/2016. All staff retraining was initiated on 2/11/2016 to ask residents what time they want to get up and do they want a access to a cell phone by the Administrator and will be completed by 2/26/2016. All newly hired staff will be trained on asking residents what time they want to get up	3/8/16

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F 242	Continued From page 8 assessment of severely impaired cognition. Review of an occupational therapy plan of care dated 01/25/16 revealed Resident #121 began therapy on 12/01/15 and would continue to receive 5 sessions a week. Observation on 02/02/16 at 9:38 AM revealed a nursing station posting which requested nursing staff to "Please have the following residents washed/dressed and leave in bed for the rehabilitation department by 5:30 AM." The list contained Resident #121's name and room number. Telephone interview with Resident #121's family member on 02/03/16 at 10:51 AM revealed Resident #121 did not like to awaken early in the morning prior to his illness. The family member explained Resident #121 "would definitely" choose to sleep later in the morning. Interview with the rehabilitation manager on 02/03/16 at 3:12 PM revealed the therapy assistants determined which residents received a 5:30 AM appointment. The rehabilitation manager reported the therapy assistant chose residents already awake and those who agreed to the early morning appointment. The rehabilitation manager explained nursing staff would inform the department if a resident required awakening for a 5:30 AM appointment. Telephone interview with Nurse Aide (NA) #1 on 02/04/16 revealed she awakened Resident #121 at approximately 5:00 AM five days a week for the therapy appointment. Interview with Resident #121's occupational	F 242	and do they want access to a cell phone during orientation. On 2/26/2016 20% of the residents will be audited for their preferred time to be awaken and their desire for a cell phone. The audits will be documented on an audit tool. The audit will be completed 5x week x 4 weeks, then weekly x 8 weeks and then monthly x 3 months. The results of the completed audit tool will be reviewed weekly by the Administrator and/or the Director of Nursing. The QI Committee will review the audits monthly x 3 to determine the continued need for and frequency of monitoring. Any recommended changes will be discussed and carried out as agreed upon at that time.	

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therapy assistant (OTA) #1 on 02/04/16 at 8:26 AM revealed Resident #121 had been on early wake up list for several months since his admission and under the care of a prior therapist. OTA #1 explained Resident #121 had the choice to go back to sleep after his care. OTA #1 reported she did not include Resident #121's family member in the decision to place his appointment at 5:30 AM.

Interview with the Director of Nursing (DON) on 02/04/16 at 9:38 AM revealed the rehabilitation department directed which residents received a 5:30 AM therapy session. The DON explained the rehabilitation manager submitted the list without input from the nursing staff. The DON reported residents should choose a wake up time and not be awakened for a 5:30 AM appointment.

2. Resident #76 was admitted to the facility on 12/13/12 with diagnoses which included dementia.

Review of Resident #76's annual Minimum Data Set (MDS) dated 01/13/16 revealed an assessment of severely impaired cognition.

Review of Resident #76's physical therapy plan of care dated 01/07/16 revealed Resident #76 began physical therapy on 12/14/15 and received 5 sessions a week.

Observation on 02/02/16 at 9:38 AM revealed a nursing station posting which requested nursing staff to "Please have the following residents washed/dressed and leave in bed for the rehabilitation department by 5:30 AM." The list contained Resident #76's name and room number.

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Interview with the rehabilitation manager on 02/03/16 at 3:12 PM revealed the therapy assistants determined which residents received a 5:30 AM appointment. The rehabilitation manager reported the therapy assistant chose residents already awake and those who agreed to the early morning appointment. The rehabilitation manager explained nursing staff would inform the department if a resident required awakening for a 5:30 AM appointment.

Telephone interview on 02/04/16 at 5:00 AM with Nurse Aide (NA) #2 revealed she awakened Resident #76 before 5:00 AM to provide assistance with bathing and dressing for the therapy session. NA # 2 reported Resident #76 occasionally did not wish to wake up but she washed and dressed Resident #76 as directed. NA #2 explained she assisted Resident #76 back to bed before the 5:30 AM appointment so he could rest.

Interview on 02/04/16 at 8:22 AM with physical therapy assistant (PTA) #1 revealed she relied on the nursing staff to inform her if the resident required awakening for the session. PTA #1 reported she was not aware staff awakened Resident #76 for the 5:30 AM session. PTA #1 could not provide a reason for the scheduled 5:30 AM session.

Interview with the Director of Nursing (DON) on 02/04/16 at 9:38 AM revealed the rehabilitation department chose which residents received a 5:30 AM therapy session. The DON explained the rehabilitation manager submitted the list without input from the nursing staff. The DON reported residents should choose a wake up time

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and not be awakened for a 5:30 AM appointment.
3. Per Resident #8's quarterly Minimum Data Set (MDS) assessment, dated 10/23/15, Resident #8 was admitted to the facility from the hospital on 10/12/2015 with diagnoses of urinary tract infection and depression. Resident #8 was assessed as cognitively intact from the MDS and had no behaviors associated with (or present for) delirium, hallucinations, or delusions. MDS revealed resident exhibited some unusual behaviors at times directed toward self, but not directed toward others (such as hitting or scratching self, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms, like screaming or disruptive sounds). There were no Preferences for Customary Routine and Activities listed in the MDS.

On 02/02/2016 at 2:42 PM, Resident #8 was lying in her geri-chair in the 300 hall hallway and as this Surveyor walked by, Resident #8 asked Surveyor why she could not have a telephone? While interviewing Resident #8, she stated she had talked with the Social Worker (SW) who was supposed to have gotten back with her. However, Resident #8 stated it had been a few weeks and she had not heard anything from the SW.

An interview was conducted with the SW on 02/03/2016 at 4:17 PM in reference to Resident #8's request for a telephone. The interview revealed a volunteer of the facility (and friend of the Resident) obtained a cell phone and had given it to the resident. The Surveyor was told the phone would no longer charge and was no longer usable. Resident #8 had been told a facility telephone was available for use if she wanted to use a telephone. If the Resident was to use the

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UNIVERSITY PLACE NURSING AND REHABILITATION CENTER	9200 GLENWATER DRIVE CHARLOTTE, NC 28262

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F 242	Continued From page 12 facility phone, however, staff would need to dial the telephone number for Resident #8 as she had called 911, police, and the fire department in the past and had often abused her use of the telephone. In an additional interview on 02/04/2016 at 3:03 PM, the SW was asked if he remembered his initial conversation with Resident #8, but he could not recall. (No documentation was offered or provided regarding conversations with Resident #8 concerning her request for a telephone.) Per conversation with the SW, Resident #8's friend/volunteer was from a church and had provided what the SW believed, was a prepaid credit card for the Resident to be able to use her telephone. According to the statement from the SW, Resident #8 was told she could use the telephone at the facility if she needed to use a phone. SW was asked who would actually pay for the telephone, the facility or the Resident. SW advised he did not think the Resident had enough funds to purchase the telephone. He also stated if Resident #8 had the money to purchase the phone, he did not believe the Resident would be able to pay for the minutes or the phone contract for any extended period of time. According to review of Resident #8's facility Trust Statement, funds were available to purchase/obtain a cellular telephone. 02/04/2016 at approximately 4:45 PM, the SW provided proof that a fax requesting assistance for purchase of a cellular telephone had been submitted on the Resident's behalf.	F 242		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES	F 246		3/8/16

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F 246	Continued From page 13 A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review, resident, and staff interviews the facility failed to place call bells within reach for 1 of 4 sampled residents (Resident #29). The findings included: Resident #29 was admitted to the facility on 08/09/10 with diagnoses which included heart failure, dementia, respiratory failure, osteoporosis, and lack of coordination. A review of the quarterly Minimum Data Set (MDS) dated 11/18/15 indicated Resident #29 had mild cognitive impairment for daily decision making. Resident #29 was characterized as making self-understood and understands. Further review of the MDS indicated Resident #29 required extensive assistance with activities of daily living (ADLs) including bed mobility, transfers, toileting, personal hygiene, and dressing and was totally dependent on staff for bathing. Resident #29's care plan dated 01/11/16 was reviewed for falls. The care plan specified the resident was at risk for falls characterized by history of falls/actual falls, injury, multiple risk factors, impaired balance, and impaired mobility. The interventions included:	F 246	Resident #29 had her call bell placed where she could access it on 2/4/2016. All residents had their call bell placed where they could be accessed on 2/4/2016 when the Department Heads and Charge Nurses made rounds. All staff retraining was initiated on 2/11/2016 that resident's call bells have to be accessible to them at all times by the Administrator and will be completed by 2/26/2016. All newly hired staff will be trained on resident's call bells being accessible to them during orientation. On 2/26/2016 20% of the residents will be audited for accessibility to their call bell. The audits will be documented on an audit tool. The audit will be completed 5x a week x 4 weeks, then weekly x 8 weeks and then monthly x 3. The results of the completed audit tool will be reviewed weekly by the Administrator and/or the Director of Nursing. The QI Committee will review the audits monthly x 3 to determine the continued need for and frequency of monitoring. Any	

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F 246	Continued From page 14 · Ensure environment is free of clutter · Have commonly used articles within easy reach · Keep call light within reach and answer timely On 02/02/16 at 9:03 AM, Resident #29 was observed setting in her wheelchair at the foot of the bed and her call light was observed to be laying in the floor behind the head of her bed. On 02/02/16 at 11:10 AM, Resident #29 was lying in her bed with her eyes closed and her call light was observed in the floor behind the head of her bed. On 02/03/16 at 9:30 AM, Resident #29's call light was observed in the floor behind the head of her bed. On 02/03/16 at 11:00 AM, an interview was conducted with Resident #29, when asked how she would call for help the resident responded, "I don't know." When the resident was asked if she would use her call light, the resident replied, "I can't find it." When the resident was asked if she would be able to use the call light if she had it in reach, the resident responded, "yes if I can feel it, but I am blind so I have to be told where it is and then I can feel around and use it." On 02/03/16 at 2:30 PM, Resident #29 was observed to be in bed and her call light was laying in the floor behind the head of her bed. On 02/04/16 at 11:15 AM, Resident #29 was observed setting in her wheelchair at the foot of her bed and her call light was observed laying in the floor behind the head of her bed.	F 246	recommended changes will be discussed and carried out as agreed upon at that time.	

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On 02/04/16 at 3:00 PM, Resident #29 was observed lying in her bed and Nurse Aide (NA) #6 was in the resident's room providing care. Resident #29's call light was observed to be wrapped around the bed rail on the right side.

On 02/04/16 at 3:00 PM, Resident #29 was asked if she was able to reach her call light and she responded, "No, I can use it if I can feel it or reach it." Resident #29 was asked if should could reach the call light with it being wrapped around the bed rail on the right side, she responded, "No" and the resident demonstrated that she was unable to reach the call light. NA #6 stated "she cannot see the call light, so she cannot use it." Resident #29 responded, "I can use it if I can feel it and reach it."

On 02/04/16 at 3:05 PM, NA #6 was observed to unwrap the call light from the bed rail and place it across Resident #29's abdominal area. Resident #29 was observed to pull the cord of the call light toward her, she placed the call light in her right hand, and pushed the call light button with no assistance. Resident #29 stated, "See, I can use it if I can feel it and know where it is."

On 02/04/16 at 3:15 AM, an interview was conducted with NA #6. She stated a residents call light was supposed to be within the residents reach at all times. NA #6 indicated she was unaware Resident #29 was capable of using her call light since she was blind and unable to see it.

On 02/04/16 at 3:30 PM, and interview was conducted with Nurse #2. She stated Resident #29 was unable to use the call light since she was blind. Nurse #2 further stated should a resident be unable to use a call light for any reason the

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F 246	Continued From page 16 expectation would be for the call light to be within reach and accessible to the resident. On 02/04/16 at 5:30 PM, an interview was conducted with the Director of Nursing (DON). She confirmed the staff were trained and expected to keep residents call lights in reach at all times. The DON stated staff members make "daily rounds" and it was everyone's responsibility to ensure call lights were within reach.	F 246		
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to clean urine from the floor and clean a chair soiled with urine for 1 (Dementia/Alzheimer's Unit) of 4 units reviewed for a clean homelike environment. The findings included: On 02/02/16 at 10:21 AM Resident #206 was observed to be visibly soiled setting in a chair in the dining area and a pool of urine was observed in the floor underneath the chair. On 02/03/16 at 9:40 AM Resident #206 was observed to be visibly soiled setting in a chair in the common living room area. The chair was	F 252	The chair and floor in the Dementia/Alzheimer's Unit was cleaned on 2/3/2016 by the second shift Floor Tech. All rooms, dining rooms and hallways will be clean of trash and spills. All chairs will be clean and free of odor. All staff retraining was initiated on 2/18/2016 to notify Housekeeping when spills are noted and when chairs are in need of cleaning and will be completed by 2/26/2016. All newly hired staff will be trained to notify Housekeeping when spills are noted and when chairs are in need of	3/8/16

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F 252	Continued From page 17 observed to be wet with a pool of urine underneath the chair. On 02/03/16 at 9:48 AM MDS nurse #2 was observed to take the resident by her left hand and escorted her across the living room area to the entrance of the dining area to Nurse Aide (NA) #4. Resident #206's shirt and pants was observed to be visibly soiled front and back from the waist area down. MDS nurse #2 stated to NA #4 "she needs to be changed, she must have split water on her." On 02/03/16 at 10:00 AM the chair in the living room area was observed to remain visibly soiled and a pool of urine underneath the chair. On 02/03/16 with continuous observations from 10:00 AM until 11:20 AM the chair in the living room area remained visibly soiled and a pool of urine remained in the floor underneath the chair. On 02/03/16 at 11:20 AM an interview was conducted with NA #4. NA #4 stated should a chair be soiled it was supposed to be removed from the unit by the housekeeping staff and sanitized. NA #4 further stated anytime urine or liquid was visible on the floor it was supposed to be immediately cleaned up. NA #4 indicated she was unaware the chair was soiled or that there was a pool of urine underneath the chair. She further indicated the MDS nurse had only communicated to her that Resident #206 was wet and needed assistance. NA #4 confirmed the chair was soiled and a pool of urine was underneath the chair. On 02/03/16 at 11:23 AM an interview was conducted with Nurse #1. She confirmed the	F 252	cleaning during orientation. Chairs and floors will be audited 5 x week x4 weeks, then weekly x 8 weeks and then monthly x 3. The results of the completed audit tool will be reviewed weekly by the Administrator and/or the Director of Nursing. The QI Committee will review the audits monthly x 3 to determine the continued need for and frequency of monitoring. Any recommended changes will be discussed and carried out as agreed upon at that time.	

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F 252	Continued From page 18	F 252		

chair was wet and there was a pool of urine underneath the chair in the common living area. Nurse #1 stated she was not made aware Resident #206 was soiled or that the chair was wet or that there was urine in the floor. Nurse #1 further stated she would have expected the housekeeping department to have been notified in order for the chair to have been removed from the unit and sanitized and for the urine to have been cleaned up out of the floor.

On 02/03/16 at 11:30 AM an interview was conducted with MDS Nurse #2. She confirmed she observed Resident #206 to be wet and she had assumed the resident had spilled water. MDS nurse #2 indicated she had not seen the resident with a cup of water nor had she observed the resident drinking water. She further indicated she was unaware the resident had incontinent episodes and was unaware the chair was wet or that there was urine in the floor.

On 02/04/16 at 2:30 PM an interview was conducted with the Housekeeping Director. He stated he would have expected the chair to have been removed from the unit immediately to be cleaned and sanitized by the housekeeping staff. The Housekeeping Director further stated he had identified a problem and was aware that all of the chairs needed to be cleaned and sanitized in the locked dementia unit. He indicated he had not had an opportunity to put together a plan or schedule for the furniture to be cleaned since he had only been with the facility 8 days. The Housekeeping Director confirmed the chairs in the locked dementia unit was stained, soiled, and needed to be cleaned.

On 02/04/16 at 3:00 PM an interview was

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F 252	Continued From page 19 conducted with the Director of Nursing (DON). The DON stated she would have expected the chair to have been removed from the unit and the urine cleaned up off of the floor immediately. On 02/04/16 at 5:30 PM an interview was conducted with the Administrator. She indicated she and the Housekeeping Director had identified a problem with the cleanliness of the chairs in the locked dementia unit. She further indicated she was aware that all of the chairs needed to be cleaned and sanitized. She stated she would have expected the chair to have been removed from the unit and the urine cleaned up off of the floor immediately.	F 252		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations, resident, and staff interviews the facility failed to keep clean and in good repair, walls and furniture in 10 rooms on 5 of 10 halls (Rooms 401, 402, 410, 412, 604, 703, 704, 805, 904, and 907). The findings included: 1. On 02/01/16 at 1:54 PM upon observing rooms on the 700 hall, peeling wallpaper was noted in room 703 along with blisters on the front surface of the wardrobe. On 02/01/16 at 2:22 PM, inspection of the 900 hall revealed torn wall paper in room 904. On 02/02/16 at 9:01 AM during observations on	F 253	Rooms 102A, 401B, 410B, 412A/B, 416, 604A, 904B, 704A and 805A will be repaired by 2/29/2016. All rooms, bathrooms and hallways were audited for need of repairs on 2/11/2016. Maintenance staff were retrained on 2/25/2016 that rooms, halls and floors must be repaired when there is a problem. A hall and 5 rooms will be audited for need of repairs 5 X week x 4 weeks, weekly x8 weeks and then monthly x 3.	3/8/16

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F 253	Continued From page 20 the 600 hall, holes in room 604 were noted. Holes (from screws) were noted in the wall under the mounted glove box which had been removed. On 02/02/16 at 9:40 AM, room 410 was observed to have peeling wallpaper at the right side of the window. Exposed sheet rock was also noted in the same area. Room number "410" had been written on the wall in black ink. The wallpaper was observed to be peeling approximately 18 inches from the exposed sheet rock. On 02/02/16 at 9:42 AM, in the shared bathroom (between rooms 410 and 408), the wallpaper was observed to be peeling at the right side of the toilet, behind the toilet, with the toilet paper holder broken and the toilet paper sitting up on the grab bar. On 02/02/16 at 10:11 AM observation of the bathroom in room 401 revealed peeling wallpaper on the walls in multiple areas. On the wall across from the toilet, beside the toilet, and on both sides of the toilet, peeling wallpaper was noted. On 02/02/16 at 10:37 AM observation of room 402 revealed the wallpaper in the bathroom walls was peeling. On 02/02/16 at 10:47 AM during observation of room 412, peeling wallpaper was noted on the walls in the room and bathroom. On 02/04/16 at 3:27 PM an interview was conducted with the facility's Maintenance Director. The Maintenance Director stated he did not maintain documentation for smaller issues that need to be repaired right away. The Maintenance Director said he was usually informed about smaller issues by "word of mouth" or by notes left on the maintenance bulletin board outside his office. Per the Maintenance Director, work orders were usually only completed for larger issues. Completed work orders were placed in a small file box and kept in the	F 253	The results of the completed audit tool will be reviewed weekly by the Administrator and/or Director of Nursing. The QI Committee will review the audits monthly x 3 to determine the continued need for and frequency of monitoring. Any recommended changes will be discussed and carried out as agreed upon at that time.	

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F 253	Continued From page 21	F 253		

Maintenance Director's office. Although a list of items needing attention/repair were identified and documented by the Administrator and Maintenance Director, there was no documentation showing the pending or expected completion dates for the room repairs needed or identified. In addition, there was no clear documentation of the repairs that had been completed.

2. On 02/01/16 at 1:09 PM when observing the 800 hall, chipped/peeled wood was noted over the bed and table in room 805-1.
On 02/02/16 at 9:31 AM, inspection of 907, revealed the door to the resident's room had a chipped layer of wood approximately 3 feet in length. The area was not sharp, but was chipped and contained scratches on the door. Although not uneven, there were cracked tiles noted at the threshold of the doorway and in the center of the hallway.
On 02/04/16 at 3:27 PM an interview was conducted with the facility's Maintenance Director. The Maintenance Director stated he did not maintain documentation for smaller issues that need to be repaired right away . The Maintenance Director said he was usually informed about smaller issues by "word of mouth" or by notes left on the maintenance bulletin board outside his office. Per the Maintenance Director, work orders were usually only completed for larger issues. Completed work orders were placed in a small file box and kept in the Maintenance Director's office. Although a list of items needing attention/repair were identified and documented by the Administrator and Maintenance Director, there was no documentation showing the pending or expected completion dates for the room repairs needed or

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identified. In addition, there was no clear documentation of the repairs that had been completed.

3. On 02/02/16 at 9:42 AM observations of the shared bathroom (between rooms 410 and 408) revealed the grout at the base of the toilet was stained and brown in color.
On 02/02/16 at 10:11 AM observation of the bathroom in room 401 revealed the base of the toilet was unclean with urine visible to both sides of the toilet. Also visible was a brown stain on the grout at the base of the toilet.
On 02/02/16 at 10:37 AM observation of room 402 revealed the grout around the base of the toilet bowl was brown in color.
On 02/02/16 at 10:41 AM in room 704, the bathroom floor was noted to be scuffed with dark colored stains.
On 02/02/16 at 11:15 AM, staff was observed waxing the floor in the room and bathroom of room 401. Upon return to the room at 11:55 AM, urine stains were still noted on both sides of the toilet and at the toilet base.
On 02/04/16 at 3:27 PM an interview was conducted with the facility's Maintenance Director. The Maintenance director stated he did not maintain documentation for smaller issues that need to be repaired right away. The Maintenance Director said he was usually informed about smaller issues by "word of mouth" or by notes left on the maintenance bulletin board outside his office. Per the Maintenance Director, work orders were usually only completed for larger issues. Completed work orders were placed in a small file box and kept in the Maintenance Director's office. Although a list of items needing attention/repair were identified and documented by the Administrator and

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F 253	Continued From page 23 Maintenance Director, there was no documentation showing the pending or expected completion dates for the room repairs needed or identified. In addition, there was no clear documentation of the repairs that had been completed.	F 253		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum	F 272		3/8/16

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F 272	Continued From page 24 Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to conduct a comprehensive assessment to identify and analyze how condition affected function and quality of life related to the risk for falls, psychoactive medication, and activities of daily living for 1 of 5 sampled residents who received psychoactive medications (Resident #38). The findings included: Resident #38 was readmitted to the facility on 06/17/15 with diagnoses which included dementia and Parkinson's disease. Review of a mental health nurse practitioner note dated 12/08/15 revealed Resident #38 received Clonazepam (anti-anxiety) 1 milligram twice daily, Risperdal (antipsychotic) 0.5 mg. twice daily, Risperdal Consta 25 mg. intramuscular injection every 2 weeks and Ativan 1 mg. IM three time daily as needed for anxiety. Review of a nurse practitioner (NP)'s note dated 12/23/15 revealed staff reported Resident #38 lost weight and appeared sedated. The NP discontinued the oral Risperdal and discontinued the scheduled Clonazepam.	F 272	On 2/22/2016 the MDS nurse completed a detailed general care plan progress note for the resident #38. The documentation is detailed related to the Psychotropic Drug Use Care Area Assessment (CAA). the documentation includes a description of the problem, name and dose of medications, contributing factors related to psychotropic drug use including sedation and gait disturbances. The documentation includes and analysis of the findings supporting the decision to proceed to care plan. On 2/25/2016, the Administrator, DON and QI Nurse began auditing each resident that received psychotropic medications last comprehensive assessment to ensure the Psychotropic Drug Use CAA was completed accurately. A detailed general care plan progress note was completed for each resident where a concern was noted. The audits was completed on . On 2/22/2016 the MDS Corporate Consultant completed an in-service with the MDS Coordinator and MDS nurses	

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F 272	Continued From page 25 Review of Resident #38's annual Minimum Data Set (MDS) dated 12/25/15 revealed an assessment of short and long term memory problems with no behaviors. The MDS indicated Resident #38 received antipsychotic and anti-anxiety medication. Review of Resident #38's Psychotropic Drug Use Care Area Assessment (CAA) dated 01/08/16 revealed no documentation of findings with a description of the problem, name and dose of medications, contributing factors and risk factors related to psychotropic drug use. The CAA indicated Resident #38 exhibited the side effect of sedation and gait disturbance and did not describe and analyze the sedation and gait. There was no documentation of an analysis of the findings supporting the decision to proceed or not to proceed to the care plan. Observations on 02/01/16 at 12:53 PM and on 02/03/16 at 8:04 AM revealed Resident #38 ambulated independently with a shuffling, unsteady gait. Interview with MDS Coordinator #1 on 02/04/16 at 2:55 PM revealed the CAA did not contain documentation of findings and analysis regarding Resident #38's psychoactive medication. MDS Coordinator #1 explained she did not realize a documented analysis was required on the CAA Interview with MDS Coordinator #2 on 02/04/16 at 3:00 PM revealed she recently became the Registered Nurse who had responsibility for MDS Coordinator #1, a licensed practical nurse. MDS Coordinator #2 explained she did not realize a documented analysis was required on the CAA.	F 272	related to accurately completing the Use of Psychotropic Drug Use CAA per the RAI manual. On 2/25/2016 the MDS nurses began auditing the Use of Psychotropic Drug Use CAAs using an audit tool titled Accuracy of Psychotropic Drug Use Audit Tool. This audit will be completed weekly x 4 weeks then biweekly x 8 weeks then monthly x 3 months by the MDS nurses. The monthly QI Committee will review the results of the Accuracy of Psychotropic Drug Use Audit Tool monthly x6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring and make recommendations for monitoring for continued compliance. The Administrator and/or DON will present the findings and recommendations of the monthly QI Committee to the Quarterly Executive QA Committee for further recommendations and oversight.	

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F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interviews and medical record review, the facility failed to include active diagnoses and accurately record the dental status for a resident when completing an admission Minimum Data Set for 1 of 23 sampled residents reviewed (Resident #59).	F 278	On 2/26/2016 resident #59 Admission Assessment was modified to accurately code resident as being edentulous and to add the diagnosis of malignant neoplasm of the temporal lobe (brain cancer), viral hepatitis and gastroesophageal reflux by	3/8/16

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F 278	Continued From page 27 The findings included: Resident #59 was admitted to the facility on 08/14/15 from the hospital. Diagnoses on admission included malignant neoplasm of temporal lobe (brain cancer), viral hepatitis, and reflux. A hospital discharge summary dated 08/14/15 recorded a discharge diagnoses of left malignant temporal tumor with oncology follow up. An admission Minimum Data Set (MDS), dated 08/21/15 assessed Resident #59 with intact cognition and did not indicate diagnoses to include cancer, viral hepatitis or reflux. The MDS also did not indicate that Resident #59 did not have any natural teeth or tooth fragments, and was edentulous. Medical record review revealed Resident #59 had physician's orders dated 08/17/15 for Prilosec 20 mg for gastroesophageal reflux disease and 08/21/15 to add the diagnoses of Hepatitis C. Resident #59 was interviewed on 02/03/16 at 1:21 PM. During the interview, Resident #59 stated she lost her dentures prior to admission to the facility and that she did not have any natural teeth. Resident #59 was observed edentulous. An interview with MDS Nurse #1 on 02/04/16 at 3:17 PM revealed she completed the admission MDS for Resident #59. MDS Nurse #1 stated she reviewed the hospital records when she completed the diagnoses section of the MDS and only included active diagnoses. MDS Nurse #1 reviewed the medical record for Resident #59 and	F 278	the MDS nurse. On 2/26/2016 the modified assessment was accepted by the National Repository. On 2/27/2016 100% of residents were assessed to determine their dental status and compare to residents' last comprehensive assessment by the MDS nurses. On 2/25/2016, the Administrator, DON and QI nurse began auditing each resident's last completed MDS assessment for accuracy of active diagnosis coding. Audit will completed by 2/27/2016. Assessments will be modified for accuracy of active diagnosis coding as necessary. All modified assessments were accepted by the National Respository on 2/27/2016/ On 2/22/2016 the MDS Coordinator and MDS nurses were in-serviced by the MDS Corporate Consultant on correctly coding section L (resident dental status) and section I(resident active Diagnosis). On 2/25/2016 the Administrator will begin auditing MDS assessments for correct resident dental status and correct active diagnosis using the Dental and Diagnosis Accuracy Audit Tool. 25% of completed assessments will be audited weekly x4 weeks, then 25% of completed assessment biweekly x 8 weeks, the 25% of completed assessments monthly x 3 months. The monthly QI Committee will review the results of the Dental and Active Diagnosis Accuracy Audit Tool monthly for 6 months	

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F 278	Continued From page 28 stated the Resident was treated for reflux on admission, had a diagnoses of brain cancer with oncology follow up and a pain regimen, and routine labs were ordered to follow up on the viral hepatitis. MDS Nurse #1 stated "I don't know how I missed these diagnoses, especially the cancer." MDS Nurse #1 further stated that Resident #59 did not have natural teeth or dentures and she knew that because she talked to Resident #59 and looked in her mouth. MDS Nurse #1 stated she did not record on the admission MDS for Resident #59 that she was edentulous.	F 278	for identification of trends, actions taken and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The Administrator and/or Director of Nursing will present the findings and recommendations of the monthly QI Committee to the Quarterly QA Committee for further recommendations and oversight.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review the facility failed to ensure handrails in the facility were free of nails, splinters, or sharp objects to prevent resident injuries for 1 of 4 sampled residents (Resident # 44). The findings included: Resident #44 was admitted to facility on 02/04/2015 with diagnoses which included type 2 diabetes mellitus and mild cognitive impairment. The annual Minimum Data Set (MDS) dated 12/11/15 revealed Resident #44 required a walker	F 323	The nail that was exposed on the handrail across from 109 was removed on 2/4/2016. A 100% audit was completed on all handrails checking for splinters and/or exposed nails by the Maintenance staff at 12:45PM on 2/4/2016. Any areas of concern were corrected when identified. All Maintenance staff were in-serviced to	3/8/16

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F 323	Continued From page 29 or wheelchair for ambulating and limited (1 person) assistance with transferring, walking in room, walking in corridor, and locomotion on unit. Resident required extensive (1 person) assistance with locomotion off unit. MDS revealed resident had a Brief Interview of Mental Status (BIMS) Score of 9 (moderately impaired cognition). During observation on 02/04/2016 at 12:0 PM, this surveyor witnessed Resident #44 using the facility's handrail on the Dogwood Hallway as an enabler (to assist in pulling her wheelchair down the hallway). As Resident #44 was pulling herself down the hall in her wheelchair, she grabbed the handrail, all of a sudden stated "ouch" and quickly pulled her hand back. As she drew back her hand, Resident #44 was observed holding the 2nd digit on her right hand. Blood was noted dripping from her finger and the Resident stated, "There is something sharp on there." (meaning the handrail). Just inside the handrail, a nail was discovered which had punctured the Resident's finger (2nd digit on right hand). She then received immediate treatment. Interview with Resident #44 on 02/04/2016 at 12:09 PM revealed her injuries had been treated and she (sitting in wheelchair) was in her room talking with other residents. Resident #44 stated, "I'm okay. Everybody makes mistakes. I have gloves (wheelchair gloves), but I did not have them on this time." The Administrator immediately summoned maintenance staff (02/04/16 at 12:02 PM) to repair the faulty handrail. The Maintenance Director removed the nail and at 12:45 on 02/04/2016, maintenance staff performed an	F 323	check for exposed nails and/or splinters on all handrails in the facility. Any concerns identified will also be corrected immediately. An audit will be conducted weekly. The Administrator and/or Director of Nursing will review the audits 5x week x 4 weeks, weekly x 8 weeks and then monthly thereafter. The audits will then be reviewed by the Monthly QI Committee for further recommendations and follow up as indicated.	

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F 323	Continued From page 30 audit of all handrails in the facility. All handrails were checked for splinters and additional exposed nails. The handrail audit revealed 1 nail was located and removed on the 300 hall, 1 was located and removed on the 600 hall, 2 nails were located and removed on the 800 hall, and 2 nails were located and removed on the 900 hall.	F 323		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 431		3/8/16

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F 431	Continued From page 31 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to discard an expired vial of Humalog (insulin) and failed to ensure 2 bottles of Heparin (blood thinner) was dated when opened in 1 of 6 medication carts. The findings included: A review of the manufacturer's instructions for Humalog insulin indicated vials must be discarded 28 days after opening. 1) On 02/04/16 at 3:35 PM, the medication cart for the 500 and 700 halls revealed a bottle of Humalog insulin with a date opened label of 12/23/15. An interview on 02/04/16 at 3:40 PM with Nurse #3 revealed the Humalog insulin should have been discarded on 01/20/16. An interview on 02/04/16 at 3:58 PM with the Director of Nursing (DON) stated expired medications should be discarded and re-ordered from the pharmacy. The DON also confirmed the Humalog insulin should have been discarded on 01/20/16. 2) On 02/04/16 at 3:36 PM, the medication cart for the 500 and 700 halls revealed 2 bottles of Heparin (blood thinner) was pulled from the	F 431	The two bottles of heparin solution that were note dated were discarded by the Director of Nursing on 2/4/2016. The vial of expired Insulin was discarded by the Director of Nursing on 2/4/2016. A 100% audit was completed on 2/4/2016 by the Director of Nursing to ensure all medications to include insulin and heparin are properly stored and labeled. All identified areas of concern were immediately corrected. An in-service was initiated with 100% of all license nurses to include Nurse #3 regarding the dating of and expiration of multi-dose vials by the facility consultant on 2/16/2016. The in-service will be completed on 2/29/2016. All newly hired licensed nurses will be in-serviced regarding dating of and expiration of multi-dose vials during new employee orientation. The Director of Nursing, Assistant Director of Nursing, Unit Manager, QI Nurse or the RN Supervisor will check all medication carts and medication rooms weekly x 4 weeks then biweekly x 8 weeks, then monthly x 3 months to ensure all multi-dose vials to include heparin and	

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F 431	Continued From page 32 medication cart and noted to be opened with no visible date when opened. An interview on 02/04/16 at 3:40 PM with Nurse #3 revealed that any nurse who opens a new bottle of medication was required to date the bottle with the date it was opened. Nurse #3 stated the 2 bottles of Heparin should have been thrown away once it was identified as opened without a date. An interview on 02/04/16 at 3:58 PM with the DON stated that it was her expectation that any time a medication was opened it should be dated.	F 431	insulin are properly dated and not expired using the multi-dose vial audit tool. All identified areas of concern will be immediately corrected. The monthly QI Committee will review the results of the multi-dose vial audit tool monthly for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The Administrator and/or DON will present the findings and recommendations of the monthly QI Committee to the quarterly Executive QA committee for further recommendations and oversight.	
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations, resident, and staff interviews the facility failed to maintain functioning call lights in resident's rooms for 1 of 13 call lights observed (Resident #75) and 2 of 13 resdient bathrooms (Rooms 104 and 108). The findings included: Resident #75 was initially admitted to the facility	F 463	The call bell for #75 and bathrooms 104 and 108 were repaired on 2/26/2016. A 100% audit was completed on 2/18/2016 by the Maintenance Supervisor to ensure all call bells were functioning properly. An in-service was initiated with the staff to	3/8/16

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F 463	Continued From page 33 on 11/20/13 with a re-admission date of 01/21/14 with diagnoses which included non-traumatic subdural hemorrhage, muscle weakness, liver failure, and lack of coordination. A review of the quarterly Minimum Data Set (MDS) dated 11/12/15 indicated Resident #75 was cognitively intact and required assistance with his activities of daily living (ADLs). Further review of the MDS indicated Resident #75 was understood and was capable of making his needs known. Review of the facility's concern logs from 08/01/15 through 02/01/16 revealed Resident #75 filed a complaint concern on 12/15/15 with the facility in related to his call light malfunction and staff had not answered the call light. The complaint concern was assigned to the facility's social worker to investigate. On 02/03/16 at 10:50 AM an interview was conducted with Resident #75. The resident stated he had resided in the room for approximately 2 years and for the past year his call light had been malfunctioning. The resident indicated the black reset button on the call lights panel affixed to the wall in his room would not reset automatically. Resident #75 stated when staff answered a resident's call light they had to always push the black button on the call light panel in the resident's room which would turn the light off in the hallway above the resident's door and that would also reset the resident's call light system to be ready for use the next time. Resident #75 indicated that when staff answered his call light they pushed the black button so the light above his door would go off and then they would have to manually pull the black button out to reset his call light system in order for him to use his call light the next time he needed it. He further indicated	F 463	notify Maintenance when a call bell in not functioning properly using a Work Order form. All newly hired staff will be in-serviced regarding notifying Maintenance when call bells are nonfunctioning. The Maintenance Supervisor and Assistant will check 20% of call bells 5 x week x 4 weeks, then weekly x 8 weeks and then monthly x 3 months for nonfunctioning call bells. The monthly QI Committee will review the results of the audits and determine the need for and/or frequency of the continued monitoring and make recommendations for monitoring for continued compliance. The Administrator and Director of Nursing will present the findings and recommendations of the monthly QI committee to the quarterly QA Committee for further recommendations and oversight.	

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should the staff fail to manually pull the black button out that his call light would not reset and the light above his door in the hallway would not illuminate and the staff would be unaware that he needed assistance. Resident #75 demonstrated the call light system malfunction at this time. Resident #75 was observed to push the call light and the light in the hall above the resident's door illuminated. Further observation revealed the black button on the wall panel in the resident's room was pushed and the light in the hallway was observed to go off. Resident #75 was observed to again push his call light and the light above his door failed to illuminate. The black button on the panel had to be manually pulled out before the call light system reset.

On 02/03/16 at 11:10 AM Resident #75 was observed to push his call light again and the light above the resident's door in the hallway illuminated. Nurse Aide (NA) #3 was observed to go into his room and ask the resident how she could assist him. NA #3 was further observed to push the black button on the panel to turn off the light in the hallway above the resident's door. She was also observed to pull the black button out to reset the Resident's call light system.

On 02/03/16 at 11:15 AM an interview was conducted with NA #3. She stated the black button on the panel had to be manually pulled out for the call lights system in Resident #75's room to be reset. NA #3 further stated Resident #75's room was the only room she was aware of that the call light system was malfunctioning. NA #3 demonstrated the Resident's call light system and the malfunction of the black button on the call light panel as described by this Resident. The NA indicated if staff was unaware of the black button

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malfunction and they did not pull the black button out after they answered Resident #75's call light he would have been unable to use the call light the next time he needed it. NA #3 indicated she was unaware of how long the Resident's call light system had malfunctioned and that she had not reported it to anyone. NA #3 stated she was aware the call light had been worked on but could not recall when.

On 02/04/16 at 1:45 PM an interview was conducted with the Social Worker (SW). He stated he was aware of the call light malfunction in Resident #75's room and that the concern was assigned to the Maintenance Director for repair. The SW further stated he was unware of how long the call light had been malfunctioning.

On 02/04/16 at 3:30 PM an interview was conducted with the Maintenance Director. He stated he was made aware of the call light malfunction on 02/03/16. The Maintenance Director indicated NA #3 had verbally communicated with him that the black button in Resident #75's room was malfunctioning and was not springing back out when pushed to reset the call light system. He further stated he had placed an order on 02/03/16 for 3 call light switch panels and one of the panels was ordered specifically for Resident #75's room. The Maintenance Director demonstrated the call light malfunction and indicated he had placed a rubber band around the black button as a spring mechanism so that the call light would reset once it was answered by nursing staff. He further indicated he had received work orders in regards to the call light malfunctioning but was unable to recall when he had received them. The Maintenance Director stated he was aware the call light system was a

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problem and that he had been working on the call light system but was able to only do so much at a time.

On 02/04/16 at 4:00 PM the Maintenance Director provided the following work orders:
*Dated 12/04/15 no time indicated-Resident #75's room-repair needed: "sink-1005-1" action taken: (filled in by maintenance) "all good" and signed with the Maintenance Director's initials
*Dated 02/22/15 at 6:30 AM-Resident #75's room-repair needed: "call light don't make sound at the nurse station however is on in patient room please need stat attention action taken: (filled in by maintenance) "All good" with maintenance director's initials
*Dated 02/28/15 at 6:30 AM-Resident #75's room-repair needed: "call light still not working at nurse station, 2nd notice, 1st done on 02/22/15, called maintenance on call x 3" action taken: (filled in by maintenance) "call light working 03/02/15"

On 02/04/16 at 4:25 PM a follow-up interview was conducted with the Maintenance Director. He stated he had worked on Resident #75's call light in the Resident's room and at the nurse's station. The Maintenance Director stated he was aware the call light system was a problem and he had been working on it. He further stated "there is a lot of work to be done at this facility and I am doing what I can."

On 02/04/16 at 6:00 PM an interview was conducted with the Administrator. She stated she expected a resident's call light in their room to function properly at all times. She further stated she was aware there had been problems with Resident #75's call light.

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2. On 02/02/2016 at 08:50 AM, three attempts to activate the call bell in the bathroom of room 104 was unsuccessful. During interview with Resident #231 the Resident stated she attempted to use the call bell in the bathroom several times, but nobody ever came to help her.

On 02/02/2016 at 3:08 PM three attempts to activate the call bell in the bathroom of room 108 was unsuccessful.

Interview with the Maintenance Director on 02/04/2016 at 3:42 PM revealed he did not know the call bell in bathrooms 104 and 108 were not working. The Maintenance Director stated, "Sometimes those lights in the bathroom work and sometimes they don't. I change the switch, then if that don't work, I have to call somebody." The Maintenance Director explained most often when he changed out the switch, the call bell worked. When asked about the call bell in the bathroom of room 108, Maintenance Director stated he knew about the call bell not working in the past. The Maintenance Director stated, "The last time I fixed it was around the first of December. I did not know the call bell in the bathroom was not working now." Maintenance Director advised most of the time when he needs to repair a small job like a wheelchair or call bell, he does not fill-out any paperwork (work orders). If new work orders are needed, staff are supposed to complete a work order and place it on the maintenance bulletin board outside of the maintenance office. When a work order is completed, the work order is filed in a small file box kept in the maintenance office.

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F 490	Continued From page 38	F 490		
F 490 SS=E	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING 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 observations, interviews with residents, family and staff, and review of medical and facility records, the facility's administration failed to sustain an effective Quality Assessment Program through implemented procedures and monitoring of these interventions that the committee put into place during 4 federal surveys of record for 3 repeat deficiencies in the areas of dignity, choices and Quality Assessment and Assurance. Findings included: This tag is cross referred to: F 520: Quality Assessment and Assurance. Based on observations, resident, family and staff interviews, and review of medical records and facility records, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in September of 2015. This was for a recited deficiency that was originally cited in August of 2015 on a Complaint survey and subsequently recited in December of 2015 on a Complaint Survey and again in February of 2016 on the current Recertification, Complaint, and	F 490	On 2/16/2016 the facility QI Committee held a meeting. The Medical Director, Administrator, DON, QI Nurse, MDS Nurse, Treatment Nurse, Maintenance Supervisor and Housekeeping Supervisor will attend QI Committee Meetings on an ongoing basis and will assign additional team members as appropriate. On 2/18/2016 the Facility Consultant in-serviced the Facility Administrator, DON, MDS Nurse, Treatment Nurse, Maintenance Supervisor, Housekeeping Supervisor related to the appropriate functioning of the QI Committee and the purpose of the committee to include identified issues related to quality assessment and assurance activities as needed and developing and implementing appropriate plans of action for identified facility concerns, to include F241 Dignity and Respect of individuality, F 242 Right to Make Choices, and F520 Quality Assessment and Assurance Committee. As of 2/18/2016, after the Facility Consultant in-service, the facility QI Committee will begin identifying other	3/8/16

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F 490	Continued From page 39 Follow up to Complaint survey. The deficiency was in the area of dignity. The facility's QAA committee also failed to maintain implemented procedures and monitor these interventions that the committee put into place in May of 2015. This was for a recited deficiency that was originally cited in April of 2015 on a Recertification and Complaint survey and subsequently recited in February of 2016 on the current Recertification, Complaint, and Follow up to a Complaint survey. The deficiency was in the area of choices. Additionally, the facility's QAA committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in January of 2016. This was for a recited deficiency that was originally cited in December of 2015 on a Complaint survey and subsequently recited in February of 2016 on the current Recertification, Complaint, and Follow-up to a Complaint survey. The deficiency was in the area of QAA. The continued failure of the facility during four federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. During 4 federal surveys of record, April 2015 Recertification and Complaint survey, August 2015 Complaint survey, December 2015 Complaint survey, and the facility's current Recertification, Complaint and Follow-up to Complaint survey of February 2016, the facility's Administrator failed to sustain an effective Quality Assurance Program due to repeat deficiencies in the areas of dignity, choices and QAA. The Administrator and Director of Nursing (DON) were both interviewed on 02/04/16 at 5:34 PM and revealed that the Administrator assisted in coordinating the facility's QAA committee which	F 490	areas of quality concern through the QI review process, for example: review rounds tools, review work orders, review Point Click Care (Electronic Medical Record), Resident Council Minutes, Resident Concern Logs, Pharmacy Reports, and Regional Facility Consultant Recommendations. The Facility QI Committee will meet at a minimum of quarterly to identify issues related to quality assessment and assurance activities as needed and will develop and implement appropriate plans of action for identified facility concerns. Corrective action has been taken for the identified concerns related to F241 Dignity and Respect of Individuality, F 242 Right to Make Choices, and F 520 Quality Assessment and Assurance Committee. The Committee will continue to meet a minimum of monthly. The QI Committee, including the Medical Director, will review monthly complied QI Report for information, review trends, and review corrective actions taken and the dates completion. The QI Committee will validate the facility's progress in correction of deficient practices or identified concerns. The Administrator will be responsible for ensuring Committee concerns are addressed through further training and other inventions. The Administrator or her designee will report back to the Executive QI Committee at the next scheduled meeting.	

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F 490	Continued From page 40 met monthly/quarterly. The Administrator stated that all department managers attended the QAA committee meetings and agenda items were derived from audits, family satisfaction surveys, resident concerns and the facility's plan of correction from previous state inspection surveys. The Administrator stated that the facility's QAA committee continued to review/monitor/audit the implemented procedures from the April 2015 state inspection survey. Any corrected areas were removed from the monthly/weekly audits, but kept as part of the facility's quarterly QAA committee meetings. The Administrator also stated that she attributed the repeat deficiency related to QAA to the staff's failure to communicate via documentation. The Administrator stated that the facility's QAA committee needed to take another look at their quality improvement manual and consider revising the agenda for their QAA committee meetings to refocus and narrow down to the specific concerns that have been repeat deficiencies (dignity, choices, QAA) in the State Inspection Complaint surveys that occurred in the facility since the April 2015 Recertification and Complaint State Inspection. The Administrator stated that the facility's QAA committee may be spreading itself too thin. The Administrator further stated that she would need to direct the facility's QAA committee to refocus, reprioritize and train department managers to look more at the big picture rather then being so task oriented.	F 490		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of	F 520		3/8/16

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F 520	Continued From page 41 nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, resident, family and staff interviews, and review of medical records and facility records, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in September of 2015. This was for a recited deficiency that was originally cited in August of 2015 on a Complaint survey and subsequently recited in December of 2015 on a Complaint Survey and again in February of 2016 on the current Recertification, Complaint, and Follow up to Complaint survey. The deficiency was in the area of dignity. The facility's QAA committee also failed to maintain implemented	F 520	On 2/16/2016 the facility QI Committee held a meeting. The Medical Director, Administrator, DON, QI nurse, MDS nurse, Treatment Nurse, Maintenance Supervisor and Housekeeping Supervisor will attend QI Committee Meetings on an ongoing basis and will assign additional team members as appropriate. On 2/18/2016 the Facility Consultant in-serviced the Facility Administrator, DON, MDS Nurse, Treatment Nurse, Maintenance Supervisor, Housekeeping Supervisor related to the appropriate functioning of the QI Committee and the	

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F 520	Continued From page 42 procedures and monitor these interventions that the committee put into place in May of 2015. This was for a recited deficiency that was originally cited in April of 2015 on a Recertification and Complaint survey and subsequently recited in February of 2016 on the current Recertification, Complaint, and Follow up to a Complaint survey. The deficiency was in the area of choices. Additionally, the facility's QAA committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in January of 2016. This was for a recited deficiency that was originally cited in December of 2015 on a Complaint survey and subsequently recited in February of 2016 on the current Recertification, Complaint, and Follow-up to a Complaint survey. The deficiency was in the area of QAA. The continued failure of the facility during four federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: 1. F 241 Dignity and Respect of Individuality: Based on observations, record review, and staff interviews the facility failed to dress residents in clothing to prevent the residents name from being visible in a locked dementia unit for 1 of 4 residents sampled for dignity (Resident #206). During a Complaint survey of August 14, 2015, the facility was cited for failure to provide personal care upon request which resulted in a resident left saturated in urine. During a Complaint survey of December 16, 2015, the facility failed to assist a resident with grooming before an out of facility appointment. On the current Recertification, Complaint and Follow-up to Complaint survey of February 04, 2016, the facility failed to promote	F 520	purpose of the committee to include identify issues related to quality assessment and assurance activities as needed and developing and implementing appropriate plans of action for identified facility concerns, to include F 241 Dignity and Respect of Individuality, F 242 Right to Make Choices, and F 520 Quality Assessment and Assurance Committee. As of 2/18/2016, after the Facility Consultant in-service, the facility QI Committee will begin identifying other areas of quality concern through the QI review process, for example: review rounds tools, review of work orders, review of Pint Click Care (Electronic Medical Record), Resident Council Minutes, Resident Concern Logs, Pharmacy Reports, and Regional Facility Consultant Recommendations. The Facility QI Committee will meet at a minimum of Quarterly to identify issues related to quality assessment and assurance activities as needed and will develop and implement appropriate plans of action for identified facility concerns. Corrective action has been taken for the identified concerns related to F241 Dignity and Respect of Individuality, F 242 Right to Make Choices, and F 520 Quality Assessment and Assurance Committee. The Committee will continue to meet a minimum of monthly. the QI Committee, including the Medical Director, will review monthly complied QI Report information, review trends, and review corrective	

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F 520	Continued From page 43 dignity when a resident on the locked unit was dressed in clothing with their name visible. The Administrator and Director of Nursing (DON) were interviewed on 02/04/2016 at 5:34 PM. The interviews revealed that the facility's QAA committee continued to discuss deficiencies from the Recertification survey in April 2015 and conducted monthly and weekly audits. The Administrator stated that she attributed the repeat deficiency related to dignity to sufficient staff rounding. 2. F 242 Right to Make Choices: Based on observation, resident, family member and staff interviews, and record review, the facility failed to give residents a choice of wake up time for 2 of 5 residents whom the facility's rehabilitation department scheduled for a 5:30 AM session (Resident #76 and #121). The facility also failed to honor a resident's choice to obtain and use a cell phone for 1 of 7 sampled residents (Resident #8). During a Recertification and Complaint survey of April 13, 2015 the facility was cited for failure to honor resident preferences related to baths, showers and wake up time. On the current Recertification, Complaint and Follow-up to Complaint survey of February 04, 2016, the facility failed to honor resident preferences for wake up time and to obtain and use of a cellular phone. The Administrator and Director of Nursing (DON) were interviewed on 02/04/2016 at 5:34 PM. The interviews revealed that the facility's QAA committee continued to discuss deficiencies from the Recertification survey in April 2015 and	F 520	actions taken and the dates completion. The QI Committee will validate the facility's progress in correction of deficient practices or identified concerns. the Administrator will be responsible for ensuring Committee concerns are addressed through further training and other interventions. The Administrator or her designee will report back to the Executive QI Committee at the next scheduled meeting.	

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conducted monthly and weekly audits. The Administrator and DON stated they attributed the repeat deficiency related to choices to a lack of documentation to support the residents who were asked their preference related to what time they received therapy services. The Administrator and DON further stated that since residents were asked their preference, that they may have changed their minds about their preference for what time they received therapy services.

3. F 520 Quality Assessment and Assurance Committee: Based on observations, resident, family and staff interviews, and review of medical records and facility records, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in September of 2015. This was for a recited deficiency that was originally cited in August of 2015 on a Complaint survey and subsequently recited in December of 2015 on a Complaint Survey and again in February of 2016 on the current Recertification, Complaint, and Follow up to Complaint survey. The deficiency was in the area of dignity. The facility's QAA committee also failed to maintain implemented procedures and monitor these interventions that the committee put into place in May of 2015. This was for a recited deficiency that was originally cited in April of 2015 on a Recertification and Complaint survey and subsequently recited in February of 2016 on the current Recertification, Complaint, and Follow up to a Complaint survey. The deficiency was in the area of choices. Additionally, the facility's QAA committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in January of 2016. This was for a recited

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deficiency that was originally cited in December of 2015 on a Complaint survey and subsequently recited in February of 2016 on the current Recertification, Complaint, and Follow-up to a Complaint survey. The deficiency was in the area of QAA. The continued failure of the facility during four federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program.

During a Complaint survey of December 16, 2015, the facility's QAA committee failed to maintain implemented procedures and monitor these interventions related to dignity with grooming and sufficient staffing on the night shift to assist residents with personal hygiene, grooming and answering call bells timely. On the current Recertification, Complaint and Follow-up to Complaint survey of February 04, 2016, the facility failed to maintain implemented procedures and monitor these interventions related to dignity, honoring resident's choices for wake up time and to obtain and use a cellular phone

The Administrator and Director of Nursing (DON) were interviewed on 02/04/2016 at 5:34 PM. The interviews revealed that the facility's QAA committee continued to discuss deficiencies from the Recertification survey in April 2015 and conducted monthly and weekly audits. The Administrator stated that she attributed the repeat deficiency related to dignity to sufficient staff rounding. The Administrator and DON stated they attributed the repeat deficiency related to choices to a lack of documentation to support the residents who were asked their preference related to what time they received therapy services. The Administrator and DON further stated that since residents were asked their preference, that they may have changed their minds about their preference for what time they

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F 520	Continued From page 46 received therapy services. The Administrator also stated that she attributed the repeat deficiency related to QAA to the staff's failure to communicate via documentation.	F 520		

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{F 241} SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to dress residents in clothing to prevent the residents name from being visible in a locked dementia unit for 1 of 4 residents sampled for dignity (Resident #206). The findings included: Resident #206 was admitted to the facility on 07/22/15 with diagnoses which included cognitive loss/dementia, behavioral symptoms, and psychotropic drug use. A review of the quarterly Minimum Data Set (MDS) dated 01/25/16 indicated Resident #206 had severe cognitive impairment and required extensive assistance with activities of daily living (ADLs). Further review of the MDS indicated Resident #206 required extensive assistance with dressing and was occasionally incontinent of bowel and bladder. A review of a care plan dated 01/25/16 indicated a problem/focus for Resident #206 which required assistance/potential to restore or maintain maximum function of self-sufficiency for dressing related to: cognitive deficit. The care plan indicated a goal for Resident #206 to be dressed appropriately with interventions for dressing to be provided with assistance and	{F 241}	Resident 206 was changed, cleaned and clean clothes donned on 2/3/2016. All residents were assessed for clean and dry clothes on 2/3/2016 by the Department Heads and Charge Nurses during their rounds. Any issues were addressed immediately. All staff retraining was initiated on 2/11/2016 that residents are to be changed, cleaned up and clean clothes donned when they are soiled by the Administrator and will be completed on 2/29/2016. All newly hired staff will be trained that residents are to be changed, cleaned up and clean clothes donned during orientation. Residents will be monitored 5 x week x 4weeks, weekly x 8 weeks and the monthly x3 months for clean and dry clothing using the Administrative Rounds Tool. The results of the completed audit tool will be reviewed weekly by the Administrator and/or the Director of Nursing. The QI Committee will review the audits monthly x 3 to determine the continued need for and frequency of monitoring. Any	3/8/16

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

Electronically Signed

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	345142	A. BUILDING _____ B. WING _____	R-C 02/04/2016

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{F 241}	Continued From page 1 supervision to ensure clothing is clean and appropriate. On 02/02/16 at 10:21 AM Resident #206 was observed to be visibly soiled setting in a chair in the dining area and a pool of urine was observed in the floor underneath the chair. On 02/02/16 at 10:45 AM Resident #206 was observed to have on dry clothing with her name written boldly in black ink around the neck area on the front portion of her shirt and across the buttocks of her grey pants. On 02/03/16 at 9:40 AM Resident #206 was observed to be visibly soiled setting in a chair in the common living room area. The chair was observed to be wet with a pool of urine underneath the chair. On 02/03/16 at 9:48 AM MDS nurse #2 was observed to take the resident by her left hand and escorted her across the living room area to the entrance of the dining area to Nurse Aide (NA) #4. Resident #206's shirt and pants was observed to be visibly soiled front and back from the waist area down. MDS nurse #2 stated to NA #4 "she needs to be changed, she must have split water on her." NA #4 was observed to escort Resident #206 into the resident's room. On 02/03/16 at 10:00 AM NA #4 was observed to escort Resident #206 out of her room in a clean dry shirt and in the same visibly soiled pants into the facility's "resident bathing area." On 02/03/16 at 10:15 AM NA #4 was observed to escort Resident #206 to a chair in the dining area in clean dry pants with the resident's name written	{F 241}	recommended changes will be discussed and carried out as agreed upon at that time.	

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{F 241}	Continued From page 2	{F 241}		

in black ink across the buttocks of Resident #206's pants.

On 02/03/16 at 11:20 AM an interview was conducted with NA #4. She stated the MDS Nurse had only communicated to her that Resident #206 was wet and needed assistance. NA #4 confirmed she changed the resident's shirt and had to take Resident #206 to the bathing area to be changed due to the resident's brief and pants being soaked with urine. NA #4 further confirmed Resident #206's name was written across the buttocks of her pants. NA #4 stated she had not paid any attention to the resident's name being on the buttocks of her pants and she was unaware of who would have written the resident's name on the outside of the pants.

On 02/03/16 at 11:23 AM an interview was conducted with Nurse #1. She indicated a resident's name was not supposed to be visible on their clothing and she would have expected the resident to have been changed into another pair of pants. Nurse #1 further indicated she was unaware of who would have written the name on the outside of Resident #206's clothing.

On 02/03/16 at 11:30 AM an interview was conducted with MDS Nurse #2. She confirmed she observed Resident #206 to be wet and she had assumed the resident had spilled water. MDS nurse #2 indicated she had not seen the resident with a cup of water nor had she observed the resident drinking water. She further indicated she was unaware the resident had incontinent episodes and was unaware the chair was wet or that there was urine in the floor. MDS nurse #2 stated should a resident's name be observed on the outside of their clothing the staff would be

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{F 241}	Continued From page 3 expected to change the resident. On 02/03/16 at 5:05 PM an interview was conducted with NA #5. She stated a resident's name was supposed to be written on the inside of their clothing. She further stated she was unaware of who had written Resident #206's name on the outside of her clothing in black ink. NA #5 indicated should a resident's name be observed on the outside of their clothing the staff would be expected to change the resident. NA #5 further indicated she had not paid any attention and was unaware Resident #206's name was boldly written across the buttocks of her pants. On 02/04/16 at 3:00 PM an interview was conducted with the Director of Nursing (DON). The DON stated her expectation would have been for the resident's clothing to be changed immediately once observed to be soiled or to be changed should the name be visible on the outside of a resident's clothing. The DON indicated she was aware of dignity concerns/issues in regards to resident's names being visible on their clothing in the locked unit. She further indicated "this has been a work in progress."	{F 241}		
{F 520} SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.	{F 520}		3/8/16

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{F 520}	Continued From page 4 The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, resident, family and staff interviews, and review of medical records and facility records, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in September of 2015. This was for a recited deficiency that was originally cited in August of 2015 on a Complaint survey and subsequently recited in December of 2015 on a Complaint Survey and again in February of 2016 on the current Recertification, Complaint, and Follow up to Complaint survey. The deficiency was in the area of dignity. The facility's QAA committee also failed to maintain implemented procedures and monitor these interventions that the committee put into place in May of 2015. This was for a recited deficiency that was originally cited in April of 2015 on a Recertification and	{F 520}	On 2/16/2016 the facility QI Committee held a meeting. The Medical Director, Administrator, DON, QI nurse, MDS nurse, Treatment Nurse, Maintenance Supervisor and Housekeeping Supervisor will attend QI Committee Meetings on an ongoing basis and will assign additional team members as appropriate. On 2/18/2016 the Facility Consultant in-serviced the Facility Administrator, DON, MDS Nurse, Treatment Nurse, Maintenance Supervisor, Housekeeping Supervisor related to the appropriate functioning of the QI Committee and the purpose of the committee to include identify issues related to quality assessment and assurance activities as needed and developing and implementing	

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{F 520}	Continued From page 5 Complaint survey and subsequently recited in February of 2016 on the current Recertification, Complaint, and Follow up to a Complaint survey. The deficiency was in the area of choices. Additionally, the facility's QAA committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in January of 2016. This was for a recited deficiency that was originally cited in December of 2015 on a Complaint survey and subsequently recited in February of 2016 on the current Recertification, Complaint, and Follow-up to a Complaint survey. The deficiency was in the area of QAA. The continued failure of the facility during four federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: 1. F 241 Dignity and Respect of Individuality: Based on observations, record review, and staff interviews the facility failed to dress residents in clothing to prevent the residents name from being visible in a locked dementia unit for 1 of 4 residents sampled for dignity (Resident #206). During a Complaint survey of August 14, 2015, the facility was cited for failure to provide personal care upon request which resulted in a resident left saturated in urine. During a Complaint survey of December 16, 2015, the facility failed to assist a resident with grooming before an out of facility appointment. On the current Recertification, Complaint and Follow-up to Complaint survey of February 04, 2016, the facility failed to promote dignity when a resident on the locked unit was dressed in clothing with their name visible. The Administrator and Director of Nursing (DON)	{F 520}	appropriate plans of action for identified facility concerns, to include F 241 Dignity and Respect of Individuality, F 242 Right to Make Choices, and F 520 Quality Assessment and Assurance Committee. As of 2/18/2016, after the Facility Consultant in-service, the facility QI Committee will begin identifying other areas of quality concern through the QI review process, for example: review rounds tools, review of work orders, review of Pint Click Care (Electronic Medical Record), Resident Council Minutes, Resident Concern Logs, Pharmacy Reports, and Regional Facility Consultant Recommendations. The Facility QI Committee will meet at a minimum of Quarterly to identify issues related to quality assessment and assurance activities as needed and will develop and implement appropriate plans of action for identified facility concerns. Corrective action has been taken for the identified concerns related to F241 Dignity and Respect of Individuality, F 242 Right to Make Choices, and F 520 Quality Assessment and Assurance Committee. The Committee will continue to meet a minimum of monthly. the QI Committee, including the Medical Director, will review monthly complied QI Report information, review trends, and review corrective actions taken and the dates completion. The QI Committee will validate the facility's progress in correction of deficient practices or identified concerns. the	

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{F 520}	Continued From page 6 were interviewed on 02/04/2016 at 5:34 PM. The interviews revealed that the facility's QAA committee continued to discuss deficiencies from the Recertification survey in April 2015 and conducted monthly and weekly audits. The Administrator stated that she attributed the repeat deficiency related to dignity to sufficient staff rounding. 2. F 242 Right to Make Choices: Based on observation, resident, family member and staff interviews, and record review, the facility failed to give residents a choice of wake up time for 2 of 5 residents whom the facility's rehabilitation department scheduled for a 5:30 AM session (Resident #76 and #121). The facility also failed to honor a resident's choice to obtain and use a cell phone for 1 of 7 sampled residents (Resident #8). During a Recertification and Complaint survey of April 13, 2015 the facility was cited for failure to honor resident preferences related to baths, showers and wake up time. On the current Recertification, Complaint and Follow-up to Complaint survey of February 04, 2016, the facility failed to honor resident preferences for wake up time and to obtain and use of a cellular phone. The Administrator and Director of Nursing (DON) were interviewed on 02/04/2016 at 5:34 PM. The interviews revealed that the facility's QAA committee continued to discuss deficiencies from the Recertification survey in April 2015 and conducted monthly and weekly audits. The Administrator and DON stated they attributed the repeat deficiency related to choices to a lack of documentation to support the residents who were	{F 520}	Administrator will be responsible for ensuring Committee concerns are addressed through further training and other interventions. The Administrator or her designee will report back to the Executive QI Committee at the next scheduled meeting.	

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{F 520}	Continued From page 7	{F 520}		

asked their preference related to what time they received therapy services. The Administrator and DON further stated that since residents were asked their preference, that they may have changed their minds about their preference for what time they received therapy services.

3. F 520 Quality Assessment and Assurance Committee: Based on observations, resident, family and staff interviews, and review of medical records and facility records, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in September of 2015. This was for a recited deficiency that was originally cited in August of 2015 on a Complaint survey and subsequently recited in December of 2015 on a Complaint Survey and again in February of 2016 on the current Recertification, Complaint, and Follow up to Complaint survey. The deficiency was in the area of dignity. The facility's QAA committee also failed to maintain implemented procedures and monitor these interventions that the committee put into place in May of 2015. This was for a recited deficiency that was originally cited in April of 2015 on a Recertification and Complaint survey and subsequently recited in February of 2016 on the current Recertification, Complaint, and Follow up to a Complaint survey. The deficiency was in the area of choices. Additionally, the facility's QAA committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in January of 2016. This was for a recited deficiency that was originally cited in December of 2015 on a Complaint survey and subsequently recited in February of 2016 on the current Recertification, Complaint, and Follow-up to a

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{F 520}	Continued From page 8 Complaint survey. The deficiency was in the area of QAA. The continued failure of the facility during four federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. During a Complaint survey of December 16, 2015, the facility's QAA committee failed to maintain implemented procedures and monitor these interventions related to dignity with grooming and sufficient staffing on the night shift to assist residents with personal hygiene, grooming and answering call bells timely. On the current Recertification, Complaint and Follow-up to Complaint survey of February 04, 2016, the facility failed to maintain implemented procedures and monitor these interventions related to dignity, honoring resident's choices for wake up time and to obtain and use a cellular phone The Administrator and Director of Nursing (DON) were interviewed on 02/04/2016 at 5:34 PM. The interviews revealed that the facility's QAA committee continued to discuss deficiencies from the Recertification survey in April 2015 and conducted monthly and weekly audits. The Administrator stated that she attributed the repeat deficiency related to dignity to sufficient staff rounding. The Administrator and DON stated they attributed the repeat deficiency related to choices to a lack of documentation to support the residents who were asked their preference related to what time they received therapy services. The Administrator and DON further stated that since residents were asked their preference, that they may have changed their minds about their preference for what time they received therapy services. The Administrator also stated that she attributed the repeat deficiency related to QAA to the staff's failure to communicate via documentation.	{F 520}		

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