STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345077	A. BUILDING ______ B. WING ______	C 05/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYBROOK REHABILITATION CENTER	**25 SUNNYBROOK ROAD RALEIGH, NC 27610**

(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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review, physician and staff interview, the facility failed to notify the physician of a resident experiencing low blood	F 157	The statements included are not an admission and do not constitute agreement with the alleged deficiencies	6/29/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 06/09/2016

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

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pressures and of staff not administering blood pressure medications as ordered for one of five sampled residents reviewed for unnecessary medications (Resident #122). The findings included:

Resident #122 was admitted to the facility on 11/19/14 and readmitted on 4/9/16. Cumulative diagnoses included, in part, hypertension, heart failure and cerebrovascular accident (CVA).

Physician orders dated 4/9/16 included the following medications for hypertension: clonidine 0.1 milligrams (mg) by mouth (po) every six hours as needed for systolic blood pressure greater than 160, Lasix 40 mg po daily, hydralazine 50 mg po three times daily, Lisinopril 10 mg po daily, Carvedilol 12.5 mg po twice daily (BID) and Alberta 300 mg po BID. There were no blood pressure parameters indicated for not administering any of the resident ' s blood pressure medications.

A nursing note dated 4/15/16 at 10:01 PM stated Carvedilol 12.5 mg and labetalol 300 mg were not administered. The note specified the resident's blood pressure (BP) was 92/75.

A nursing note date 4/20/16 at 12:22 PM indicated Carvedilol 12.5 mg, labetalol 300 mg and Lisinopril 10 mg were not administered because the resident's BP was 93/50.

A nursing note dated 4/21/16 at 12:38 PM stated Lasix 40 mg, Carvedilol 12.5 mg, Lisinopril 10 mg and labetalol 300 mg were not administered because the resident's BP was 90/44.

A nursing note dated 4/22/16 at 6:3PM indicated

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herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.

1) Interventions for affected residents:

On 05/23/2016, The facility Unit Manager (UM) notified the physician regarding Resident #122 low blood pressure and blood pressure medications not being administered as ordered.
On 05/23/2016, Resident #122 was evaluated by the physician and new orders were obtained establishing parameters for blood pressure medications.

2) Interventions for residents identified as having potential to be affected:

An audit was performed by the pharmacy consultant on 05/31/2016 to determine need for follow up of current resident orders. Medication orders were evaluated for addition of parameters. Documentation will be placed in the resident medical record for held orders and physician notification. After completion of audit, no additional notifications were required.

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labetalol 300 mg and Carvedilol 12.5 mg were not administered because the resident's BP was 97/60.

A nursing note dated 4/25/16 at 12:23 PM stated Carvedilol 12.5 mg and Lisinopril 10 mg were not administered because the resident's BP was 99/54.

A nursing note dated 5/2/16 at 6:13PM indicated Carvedilol 12.5 mg, labetalol 300 mg were not administered because the resident's BP was 100/49 and 100/59.

A nursing note dated 5/9/16 at 12:55 PM stated Carvedilol, labetalol 300 mg, Lisinopril mg were not administered because the resident's BP was 91/52.

A nursing note dated 5/11/16 at 12:57 PM stated labetalol 300 mg, Carvedilol 12.5 mg and Lisinopril mg were not administered because the resident's BP was 96/51.

A nursing note dated 5/16/16 at 11:23 AM indicated Carvedilol, labetalol 300 mg and Lisinopril 10 mg were not administered because the resident's BP was 98/53.

A review of the resident's medical record revealed no documentation that the physician was notified of the resident experiencing low blood pressures or that the resident ' s blood pressure medications were not being administered as ordered.

On 5/18/16 at 12:43 PM, an interview was conducted with the medication aide. She stated she worked from 10:00AM until she could finish

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3)Systemic Change

All Licensed Nurses and Medication Aides across all shifts (including weekend and as needed (PRN) scheduled) will be educated by 06/29/2016 by the facility Staff Development Coordinator (SDC) or Regional Clinical Director regarding notifying the Physician for medications which were held or not administered as per physician order and importance of documenting the notification in the resident medical record. Upon holding an ordered medication, Licenses Nurses should notify the Physician and Unit Manager/or Director of Nursing during their scheduled shift. Attempts to notify the physician of medications held will be documented in the resident medical record. During daily clinical rounds, facility Director of Nursing, Unit Manager or Weekend Supervisor will review 24 hour report to ensure physician notification and follow-up of medications held as applicable.

Newly hired Licensed Nurses and Medication Aides will be educated by the facility Staff Development Coordinator (SDC) during their orientation period on facility process of ensuring physician and Unit Manager/or Director of Nursing notification of medications being held and documenting this notification in the resident medical record.

4) Monitoring of the change to sustain system compliance ongoing:

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F 157	Continued From page 3 medication pass in the evening. She stated there were no parameters for Resident #122's medications but she would not give him his blood pressure medications if his systolic blood pressure was less than 100. She stated that was too low to give those medications. The medication aide stated she told the nurse on the floor when she did not administer the resident's medications as ordered. On 5/18/16 at 4:10PM, an interview was conducted with the Director of Nursing regarding Resident #122's blood pressure medications. The Director of Nursing reviewed the nursing progress notes and did not find any documentation that the physician was aware of the resident's low blood pressures and that the blood pressure medications were not administered as ordered. She stated there was not a policy regarding holding medications and it would be nursing judgment. She stated she was sure that the nursing staff informed the physician about the resident's low blood pressures and not administering the resident's blood pressure medications as ordered. On 5/19/16 at 11:09 AM, an interview was conducted with nurse #3. She stated the first time she heard about the medication aide not administering Resident #122's blood pressure medications was yesterday when the medication aide told her she was asked about not administering the medications. She stated she had not been informed at any time that the resident's medications were not administered as ordered due to low BP. Nurse #3 further stated, if she had been notified, she would have called the resident's physician after the first time to see if parameters would be ordered or changes made	F 157	An audit will be performed by the Unit Managers to ensure proper physician notification of any medications withheld. Held medications will be reviewed during clinical meeting for appropriate documentation. Audits will be performed on ten (10) residents; five(5) times per week for two(2)weeks, then two(2) times per week for two(2) weeks, then weekly for eight(8) weeks to ensure physician notification of medications which are held. Monthly for a minimum of three months, the DON will report notification of physician audit results to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	

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F 157	Continued From page 4 in the medication orders. On 5/19/16 at 2:00PM, an interview was conducted with Resident #122's physician. She stated she was not notified of Resident #122 experiencing low blood pressures and of staff not administering the resident's blood pressure medications as ordered until today. She said she reviewed the resident's medications today and had changed some medications. The physician stated she should have been notified when the resident's medication was held more than one time.	F 157		
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 record review, observation and staff interview, the facility failed to treat residents with respect and dignity by leaving a resident wet, placing a towel between resident's leg instead of using incontinence brief and leaving a dependent resident in the middle of feeding for extended period of time for 2 (Residents # 35 & #31) of 3 sampled residents reviewed for dignity. Findings included: 1. Resident #35 was admitted to the facility on 2/12/16 and readmitted 4/21/16 with multiple diagnoses including paraplegia, a history of pressure ulcer, muscle weakness and	F 241	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.	6/29/16

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depression.

The Minimum Data Set (MDS) dated 2/19/16 indicated the resident was assessed as being cognitively intact. The MDS indicated the resident was assessed with adequate vision and was not assessed with behavioral symptoms. The MDS indicated the resident required extensive assistance with one person physical assist for toileting.

The Plan of Care revised on 5/5/16 indicated the resident had the potential for impaired skin integrity related to decreased mobility and frequent bladder incontinence. The interventions included to provide extensive assistance as needed with toileting.

An interview was conducted with Resident #35 on 5/18/16 at 12:00 PM. The resident stated he had not been checked for incontinence since 5:00 AM that morning. He stated he was not aware of when he experienced episodes of incontinence. Resident #35 stated his sitters had checked him for wetness at different times and informed the staff when incontinence care was needed, but were not responsible for checking him for wetness. He stated the first shift nursing assistant had entered his room to deliver and pick up his breakfast tray that morning, but had not checked him for wetness. The resident stated that his sitter was not present in his room at 5:00 AM that morning. He stated the sitter had come in around 8:30 AM. He stated the sitter has come in at different times and has not come every day. The resident stated he laid in wet incontinence brief on another day for approximately 12 hours. The resident stated approximately one week ago, a nursing assistant told him they had run out of

F 241

1) Interventions for affected residents:

Resident #35 was discharged to the hospital on 05/26/16 for cardiac evaluation and returned to the facility on 06/07/17. Incontinence briefs are used. Towels are not used in briefs.

Resident #31 was evaluated for any weight loss by the facility Registered Dietician. Also, the resident was observed during tray service times by the facility Unit Manager and/or Nurse Supervisor for one (1) week without any continued problems. After evaluation and observation, Resident #31 did not have identified weight loss and was assisted with meals as per care plan.

2) Interventions for residents identified as having the potential to be affected:

Scheduled Administrative Staff, Licensed Nurses and Nurse Aides will participate in tray service to residents. An overhead page will be utilized to alert staff of arrival of trays to a particular hall or dining room. Assistance with dining will not be interrupted except for in case of emergencies. Residents using incontinence briefs will not have additional towels placed in brief. Staff education on ADL care and supplies incorporates this procedure.

3) Systemic Change

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incontinence briefs and placed a towel between his legs.

A clock was observed to be hanging on the wall of the resident's room on 5/18/16 at 12:00 PM.

An interview was conducted with Nursing Assistant (NA) #1 on 5/18/16 at 12:15PM. NA #1 stated the resident was alert and oriented. NA #1 stated the resident was not aware of when he experienced episodes of incontinence. NA #1 stated she was expected to round on the residents every 2 hours. NA#1 stated she had not been checking the resident for wetness. She was depending on his paid sitters to let her know when he needed to have his incontinence brief changed. NA#1 stated she had not placed a towel between the resident's legs.

NA #1 was observed performing incontinence care for Resident #35 on 5/18/16 at 12:30 PM. The incontinence brief taken off of the resident was observed to be saturated with urine. No ring was observed on the incontinence brief. No redness of the skin was observed. The draw sheet and bottom sheet were observed to be wet.

An interview was conducted with Resident #35 on 5/18/16 at 3:00PM. The resident stated he did not like having to lay in a wet incontinence brief from sometime after 5:00 AM until 12:30 PM. The resident also stated he did not like having a towel put between his legs to take the place of an incontinence brief.
2. Resident # 31 was admitted to the facility on 3/23/11 with multiple diagnoses including Diabetes Mellitus. The annual Minimum Data Set (MDS) assessment dated 2/28/16 indicated that Resident #31 had memory and decision making

F 241

All Licensed Nurses and Nurse Aides (across all shifts including weekend and as needed(PRN) scheduled) will be re-inserviced by the facility Staff Development Coordinator or Regional Clinical Director by 06/29/2016 regarding assistance with tray service, timely tray pass and completion of task without interruptions.

Newly hired Licensed Nurses and Nurse Aides will be educated during their orientation period by the facility Staff Development Coordinator regarding assistance with tray service, timely tray pass and completion of task without interruptions as well as ADL care use and obtaining supplies.

Department Managers will assist with tray service as needed.

On 06/06/2016, a small dining group was established for residents that require total assistance with meals. Facility meal delivery times were adjusted to include delivery of meal trays to the secondary dining room for residents included in the small dining group. Licensed Nurses and Nurse Aides will assist and monitor in secondary dining room.

4) Monitoring of the change to sustain system compliance ongoing:

Department Managers, Weekend Supervisor or Manager on Duty will make facility rounds during tray service to

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F 241	Continued From page 7 problems and needed extensive assistance with eating. On 5/17/16 at 2:20 PM, NA # 8 was observed feeding Resident #31 in her room. At 2:25 PM, the resident in room 38 had activated her call light and NA #8 was observed leaving Resident #31 to answer the light. At 2:35 PM, NA #8 was observed coming out of room 38. When interviewed, NA #8 stated that the resident in room 38 had requested to be put back to bed and the resident was wet so she had provided incontinent care. When NA #8 returned to the room of Resident #31 to continue feeding her, the tray was gone. On 5/17/16 at 2:36 PM, Nurse #4 was interviewed. Nurse #4 stated that the tray for Resident #31 was taken out of the room because NA #8 had finished feeding the resident. On 5/17/16 at 4:05 PM, the administrator indicated that he was informed that a NA who was feeding a resident had left the resident to take care of another resident. He indicated that this was a dignity issue and the NA should have asked another staff member to take care of another resident.	F 241	assure timely distribution and assistance with meals. Facility rounds will randomly include all meals during weekdays and weekends. Facility rounds will occur three (3) times weekly for three (3) months. Any issues identified with timely distribution and assistance will be reported to Unit Managers or Director of Nursing for evaluation. ADL care interviews and observations will be conducted by department heads in daily rounds. Linen checks are conducted daily and includes incontinence care checks. Monthly for a minimum of three(3) months, the DON will report any disruption in tray service, ADL/linen/brief audits or lack of timely assistance to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audit to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	
F 254 SS=D	483.15(h)(3) CLEAN BED/BATH LINENS IN GOOD CONDITION The facility must provide clean bed and bath linens that are in good condition. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	F 254	The statements included are not an	6/29/16

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F 254	Continued From page 8 facility failed to provide clean linens for one of three sampled residents observed for pressure ulcer care (Resident #105). The findings included: Resident #105 was admitted to the facility on 4/6/16. Cumulative diagnoses included left calcaneal (heel bone) osteomyelitis right heel and left heel foot ulcers. An Admission Minimum Data Set (MDS) dated 4/13/16 indicated Resident #105 was moderately impaired in cognition. On 5/17/16 at 2:30PM, an observation of pressure ulcer care was conducted. Resident #105 was lying in bed and a sheet was observed bundled under his left leg. There was a large amount of red blood and brown liquid noted on the sheet. Nurse #2 was present and stated the sheet had dried blood on it and should have been changed when it became soiled. On 5/17/16 at 2:30PM, an interview was conducted with NA#11. She stated she was the NA for Resident #105 on day shift. She stated she had turned Resident #105 but had not pulled the covers down and did not know the sheet was soiled. NA #11 stated she did not make rounds with the night staff at shift change and said she had not had a chance to give him his bath as she had 16 residents on her assignment and had not had time because she had been busy getting residents fed, bathed, etc. On 5/19/16 at 4:13PM, an interview was conducted with the Director of Nursing who stated she expected linens to be changed at time they became soiled.	F 254	admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1) Interventions for affected residents: On 05/26/2016, Resident #105 was evaluated by the facility Wound Care Nurse for changes in plan of care. After evaluation, no changes were made to plan of care. The Unit Manager or Weekend Supervisor observed Resident #105 daily for two weeks for issues with soiled linen. After observations, no issues were identified with soiled linens. 2) Interventions for residents identified as having the potential to be affected: During shift rounds, Nurse Aides will evaluate linens for needed changes. If linens are noted to be soiled, the linens will be changed immediately or as soon as feasible dependent on the resident situation (eating, sleeping, choice etc)changed to ensure cleanliness. Linens on beds will be regularly changed two times per week and as needed.	

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F 254	Continued From page 9	F 254	3) Systemic Change Licensed nurses and Nurse Aides (across all shifts including weekend and as needed (PRN) scheduled) will be re-inserviced by 06/29/16 by the facility Staff Development Coordinator or Regional Clinical Director regarding appropriate linen changes and personal care of residents. Newly hired Licensed Nurse and Nurse Aides will be educated by the Staff Development Coordinator during their orientation period regarding appropriate linen changes and personal care of residents. By 06/20/16, Linen supplies will be evaluated by Housekeeping to determine need for additional linens. If linen supply is determined to not be sufficient, a linen order will be purchased prior to 06/29/16. Stocked linen carts will be available to Nurse Aides across all shifts including nights and weekends. 4) Monitoring of the change to sustain system compliance ongoing: Shift rounds will include linen checks by Nurse Aides. Unit Managers and Licensed nurses will observe for cleanliness of linens to ensure they are not soiled. Any issues identified will be reported to the Director of Nursing via audit form for	

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F 254	Continued From page 10	F 254	evaluation. Results will be reviewed weekly for (3) months. Monthly for a minimum of three months, the DON will report identified soiled linen issues to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audit to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	
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;	F 272		6/29/16

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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 Data Set (MDS); and
Documentation of participation in assessment.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility failed to completely assess a resident on the comprehensive assessment in the area of mental status for one of three residents (Resident #14) reviewed for participation in care planning.
The findings included:

Resident #14 was admitted to the facility on 1/4/16. The admission Minimum Data Set (MDS) assessment dated 1/11/16 indicated Resident #14 had clear speech, was able to make herself understood, and was able to understand others. Section C, the Cognitive Patterns section, was not fully completed. Question C0100 required an answer that indicated if a Brief Interview for Mental Status (BIMS) was conducted with Resident #14. This question was coded with a dash that indicated the question was not answered. The remaining questions in the BIMS section, questions C0200 through C0500, were also coded with dashes that indicated the

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1) Interventions for affected residents:

Resident #14 was assessed by the facility Social Worker during a quarterly assessment in April, 2016. The resident BIMS score was 3.

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F 272	Continued From page 12 questions were not answered. An interview was conducted on 5/19/16 at 9:30 AM with the Social Worker (SW). She indicated the SW was responsible for completing Section C of the MDS. Section C of the admission MDS dated 1/11/16 for Resident #14 was reviewed with the SW. She indicated the previous SW who was no longer employed at the facility had completed Section C of the admission MDS dated 1/11/16 for Resident #14. She revealed that the BIMS should have been conducted for Resident #14. She stated that the BIMS was to be attempted for all residents unless they were rarely or never understood. She indicated Resident #14 had some confusion at times, but that the interview should have been attempted. An interview was conducted on 5/19/16 at 5:00 PM with the Director of Nursing (DON). She indicated it was her expectation that all MDS assessments were fully completed.	F 272	2) Interventions for residents identified as having the potential to be affected: A facility audit will be completed by the facility Minimum Data Set (MDS) Coordinator and Director of Nursing on Section "C" of all current resident assessments completed from May 15, 2016 - June 15, 2016 to ensure Section "C" is fully completed and assessed appropriately. This audit will be completed by 06/29/2016. If any resident Section "C" assessment is noted to not be fully completed the assessment will be modified and Section "C" will be updated as appropriate. 3) Systemic Change On 06/16/2016, the facility Social Services Director and MDS Coordinator were in-serviced by the facility Staff Development Coordinator and/or Regional Clinical Director regarding completion of BIMs according to RAI manual guidelines. Emphasis included: All assessments should be completed accurately to include addressing mental status within assessment window. BIMS assessment should be attempted for all residents unless they are rarely or never understood. Residents rarely or never understood should have interview conducted of staff and/ or family to determine mental status.	

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F 272	Continued From page 13	F 272	The facility Corporate Clinical Process Analyst (The regional minimum data set consultant) will audit Section "C" of ten (10) resident assessments completed for the month to ensure section is fully completed and accurate. This audit will be performed monthly for three(3) months. Audit results will be reviewed with the facility Director of Nursing and re-education to facility Social Worker and MDS Coordinator by the facility Corporate Clinical Process Analyst will be provided as appropriate. 4) Monitoring of the change to sustain system compliance ongoing: The facility Director of Nursing will present audits for Section "C" assessment to the QAPI Committee weekly for three(3) months. QAPI Committee will review concerns for patterns and make recommendations to assure compliance is maintained. QAPI Committee will determine need for further auditing beyond 3 months.	
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	F 278		6/29/16

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F 278	Continued From page 14 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 medical record review and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessments accurately for active diagnosis for 2 of 5 sampled residents (Resident #39 and #122) reviewed for unnecessary medications. The findings included: 1. Resident #39 was readmitted to the facility on 7/3/14. Multiple diagnoses included peripheral vascular disease, hypothyroidism, hyperlipidemia, hypertension, GERD, insomnia, anemia, TIA, multiple fracture of ribs. A Quarterly Minimum Data Set (MDS) dated 3/16/16 indicated Resident #39 was cognitively intact. Section I of the MDS was reviewed and	F 278	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1) Interventions for affected residents:	

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F 278	Continued From page 15 there were no active diagnoses noted. On 5/18/2016 at 5:30PM, an interview was conducted with the MDS coordinator. She stated she thought if there was no physician documentation within the previous 7 day look back period related to a diagnosis, she could not code it as an active diagnosis and must have misunderstood what should be included in the active diagnosis section. 2. Resident #122 was admitted to the facility on 11/19/14 and readmitted to the facility on 4/9/16. Multiple diagnoses included coronary artery disease, history of deep vein thrombosis heart failure and atrial fibrillation. The May 2016 physician ' s orders was reviewed and included an order for Coumadin (blood thinner) 3 milligrams daily for atrial fibrillation. A Quarterly Minimum Data Set (MDS) dated 4/4/16 indicated Resident #122 was moderately impaired in cognition. Section I of the MDS was reviewed and there was not an active diagnosis of atrial fibrillation indicated. On 5/18/2016 at 4:27 PM, an interview was conducted with the MDS coordinator. She stated she should have indicated atrial fibrillation as an active diagnosis and it was overlooked.	F 278	Resident #39 had assessment modified to include current diagnoses. Resident # 122 had assessment modified to include current diagnoses. 2) Interventions for residents identified as having the potential to be affected: A facility audit of Section "I" of the MDS assessment will be completed by the MDS Nurse(s). Audit will be completed on most recent completed assessment for all current residents. This audit will ensure and confirm accuracy of coding for diagnosis (Section "I"). Any assessments noted with incorrect coding will be modified. This audit will be completed by 06/29/16. 3) Systemic Change: On 06/14/16, the Minimum Data Set (MDS) MDS Nurse was in-serviced by the facility Staff Development Coordinator and/or Regional Clinical Director regarding appropriate coding of diagnoses on the MDS. The RAI manual was reviewed related to Section I, diagnoses coding. The facility MDS Nurse will review all assessments for completed diagnoses and compare to the Medication Administration Record(MAR) and/ or physician documentation for accuracy. Diagnoses will be reviewed upon admission and subsequent assessments for appropriateness. MDS Nurse will check and verify all diagnoses prior to	

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F 278	Continued From page 16	F 278	locking assessments. Weekly for three(3) months, the facility Corporate Clinical Process Analyst (The regional minimum data set consultant) will audit Section "I" of completed MDS assessments for ten(10) residents. Audit findings will be discussed with the Director of Nursing. Any concerns related to diagnoses will be discussed with the Physician by the facility Director of Nursing. 4) Monitoring of the change to sustain system compliance ongoing: The facility Director of Nursing will present Section "I" audit results to the QAPI Committee monthly for three(3) months. The QAPI Committee will review make recommendations to assure compliance is maintained ongoing and/or determine need for further auditing beyond three(3) months.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in	F 280		6/29/16

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disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff, family and resident interview, the facility failed to invite residents/responsible party to participate in the care planning meetings for 3 (Residents #126, #51 & # 14) of 3 sampled residents reviewed for care planning and failed to complete a comprehensive care plan within 7 days after the completion of the assessment for 1 (Resident #18) of 5 sampled residents reviewed for unnecessary drugs. Findings included:

1. Resident # 126 was admitted to the facility on 4/13/14 with multiple diagnoses including Congestive Heart Failure (CHF). The annual Minimum Data Set (MDS) assessment dated 3/30/16 indicated that Resident #126's cognition was intact.

On 5/16/16 at 11:47 AM, Resident # 126 was interviewed. The resident stated that she had been at the facility for 2 years and had not been invited to participate in care plan meetings.

The social services progress notes and the care plan conference meeting notes for Resident #126 were reviewed. There were no documentation

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1) Interventions for affected residents:

Resident # 126 care plan meeting was held on 05/26/16. Attendees of the care plan meeting included the following: The facility Director of Nursing, Dietary Manager, Resident #126 and Responsible Party of Resident #126

Resident # 51 care plan meeting was held on 05/31/16.
Attendees of the care plan meeting

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that Resident #126 had been invited or participated in the care plan meetings.

On 5/18/16 at 8:45 AM, the social worker was interviewed. She stated that she was responsible for inviting residents/responsible party (RP) in care planning meetings. She had sent letters to the RP and invited residents verbally and these should have been documented on the social service progress notes or the care plan meeting conference notes. The social worker had checked the social service progress notes and the care plan conference notes and acknowledged that there were no documentation to indicate that the resident was invited or had participated in the care plan meetings.

On 5/19/16 at 10:30 AM, the MDS Nurse was interviewed. The MDS Nurse stated that it was the responsibility of the social worker to invite the resident/RP to attend the care plan meeting. She added that she was made aware that the resident /RP had not been invited to the care plan meetings and the social worker was working on a plan of correction to correct the issue.

On 5/19/16 at 4:20 PM, the Director of Nursing was interviewed. She stated that she expected the resident/RP to be invited to the care plan meetings.

2. Resident #51 was admitted to the facility on 6/17/15 with multiple diagnoses including Chronic Obstructive Pulmonary Disease (COPD). The significant change in status MDS assessment dated 5/2/16 indicated that Resident #51 ' s cognition was intact.

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included the following: Resident #51 and Son of Resident #51, Minimum Data Set(MDS) Nurse, Licensed Nurse and Dietary Manager.

Resident # 14 has care plan meeting scheduled for 06/17/16.

On 04/22/16 and 04/24/16, Resident #18 care plan was updated by the facility Minimum Data Set (MDS) Coordinator.

2) Interventions for residents identified as having the potential to be affected:

All current residents will be assessed by the facility Social Services Director for care plan meeting needs by 06/29/2016. Any resident noted with no care plan meeting within previous quarter will have a care plan meeting scheduled. Prior to scheduled care plan meeting, a review will be completed by the facility MDS Coordinator for care plan updates as appropriate.

A facility audit will be completed by the facility MDS Coordinator, Unit Manager or Regional Clinical Director by 06/29/2016 on current facility residents to ensure a comprehensive care plan has been completed as appropriate.

3) Systemic Change

Quarterly and as needed, the facility Social Services Director will schedule care

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On 5/16/16 at 11:27 AM, Resident # 51 was interviewed. The resident stated that she had been at the facility for almost a year and had not been invited to participate in care plan meetings.

The social services progress notes and the care plan conference meeting notes for Resident #51 were reviewed. There were no documentation that Resident #51 had been invited or participated in the care plan meetings.

On 5/18/16 at 8:45 AM, the social worker was interviewed. She stated that she was responsible for inviting residents/responsible party (RP) in care planning meetings. She had sent letters to the RP and invited residents verbally and these should have been documented on the social service progress notes or the care plan meeting conference notes. The social worker had checked the social service progress notes and the care plan conference notes and acknowledged that there were no documentation to indicate that the resident was invited or had participated in the care plan meetings.

On 5/19/16 at 10:30 AM, the MDS Nurse was interviewed. The MDS Nurse stated that it was the responsibility of the social worker to invite the resident/RP to attend the care plan meeting. She added that she was made aware that the residents/RP had not been invited to the care plan meeting and the social worker was working on a plan of correction to correct the issue.

On 5/19/16 at 4:20 PM, the Director of Nursing was interviewed. She stated that she expected the resident/RP to be invited to the care plan meetings

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plan meetings for facility residents. The Social Services Director will send out care plan meeting invitation letters to residents and families. A follow up phone call will be completed by the Social Services Director to the family and/or resident prior to the scheduled care plan meeting to ensure receipt of the care plan meeting invitation letter and confirm attendance to scheduled care plan meeting. Documentation will be placed in the resident's medical record and care plan meeting invitation letters will be placed into the resident's medical record by the facility Social Services Director.

MDS will provide assessment schedules to the Social Services Director to aide in scheduling care plan meetings as per resident assessment date.

On 06/16/16, the facility Social Services Director and MDS Nurse were in-serviced by the Staff Development Coordinator and Regional Clinical Director regarding invitation of residents and families to care plan Meetings to include documentation in electronic record and completion of comprehensive care plans within 7 days after completion of the resident comprehensive assessment.

Scheduled care plan meetings for the day will be discussed in morning meeting (Monday - Friday) by the Social Services Director.

Resident care plan reviews will be performed upon admission, quarterly and

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3. Resident #14 was admitted to the facility on 1/4/16 with multiple diagnoses including heart failure and major depressive disorder.

The quarterly Minimum Data Set (MDS) assessment dated 4/5/16 indicated Resident #14 had significant cognitive impairment.

A family interview was conducted by phone with Resident #14's responsible party (RP) on 5/16/16 at 3:00 PM. She indicated she had not been invited to participate in care planning for Resident #14.

A review of the medical record for Resident #14 revealed no documentation of a care plan meeting since her admission to the facility on 1/4/16.

An interview was conducted on 5/19/16 at 9:30 AM with the Social Worker (SW). She indicated that care plan meetings were held with the residents and/or RPs for participation in the care planning process. She reported she was responsible for coordinating and scheduling care plan meetings with residents and/or RPs. She stated that care plan meetings were held every 90 days and as needed. The SW reviewed the medical record for Resident #14. She revealed Resident #14 had not had a care plan meeting since admission (1/4/16). She reported she began working at the facility in February 2016 and a care plan meeting had not been held for Resident #14 while she had been at the facility. She stated there was no documentation in Resident #14's record that indicated a care plan meeting was held prior to the time she began

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as needed. Reviews will be monitored and performed during clinical meeting by the Interdisciplinary Team which includes the Director of Nursing, Unit Manager, Social Services Director, MDS Nurse and Dietary Manager.

The facility Director of Nursing will perform an audit of care plan meeting invitations, follow-up phone calls and scheduled care plan meetings to ensure completion. The audit will be completed weekly for three(3) months.

4) Monitoring of the change to sustain system compliance ongoing:

The facility Director of Nursing will present to the QAPI Committee audits of care plan invitations, care plan updates and scheduled/completed care plan meetings monthly for three(3)months. The QAPI Committee will review and make recommendations to assure compliance is maintained ongoing and determine need for further auditing beyond 3 months.

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working at the facility. The SW indicated Resident #14 should have had an initial care plan meeting shortly after admission as well as at least one additional care plan meeting since admission. She stated she was in the process of implementing a new system to coordinate and document care plan meetings.

An interview was conducted with the Director of Nursing on 5/19/16 at 5:00 PM. She indicated her expectation was for the resident and/or RP to be included in the care planning process. She additionally indicated that care plan meetings were to be held after admission, quarterly, and as needed.

4. Resident #18 was admitted to the facility on 3/29/16 with multiple diagnoses including encephalopathy, major depressive disorder, and mild intellectual disabilities.

The social service assessment dated 4/3/16 indicated Resident #18 had a diagnosis of major depressive disorder and received antidepressant medication. Resident #18 had rejected care 1 to 3 days since admission and yelled out for the nurse at times. Resident #18 received psychiatric services.

Resident #18's admission Minimum Data Set (MDS) assessment dated 4/4/16 indicated his cognition was intact. He was indicated to have rejected care 4-6 days during the review period, and had received antidepressant medication 6 days during the review period. The Care Area Assessment (CAA) indicated the following

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triggered care areas: cognitive loss, communication, activities of daily living functional/rehabilitation potential, behavioral symptoms, urinary incontinence, falls, nutritional status, pressure ulcer, and psychotropic drug use. All triggered CAAs were indicated to be care planned.

The comprehensive care plan for Resident #18 was reviewed. The care plans for cognitive loss, communication, behavioral symptoms, and psychotropic drug use were not completed within seven days of the completion of the comprehensive assessment.

A care plan for behavioral symptoms was created on 4/22/16. This was 18 days after the completion of the comprehensive assessment.

Care plans for cognitive loss, communication, and psychotropic drug use were created on 4/24/16. This was 20 days after the completion of the comprehensive assessment.

An interview was conducted on 5/18/16 at 9:30 AM with the MDS Coordinator. She stated that care planning was a group effort, but she was responsible for entering the care plan information into the electronic medical record. The care plan for Resident #18 was reviewed with the MDS Coordinator. She indicated she was unable to say why the care plans related to cognitive loss, communication, behavioral symptoms, and psychotropic drug use were created after the required timeframe for Resident #18. She revealed this was an error. She stated she had created care plans for Resident #18's other CAA triggered areas within the required timeframe.

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F 280	Continued From page 23 An interview was conducted with the Director of Nursing (DON) on 5/19/16 at 5:00 PM. She indicated her expectation was that comprehensive care plans were to be fully completed within the required timeframe.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff and resident interview, the facility failed to ensure that medications were not left at the resident's bedside for 2 (Residents # 51 & #203) of 2 sampled residents observed with medications at bedside and failed to obtain CBC (complete blood count), CMP (comprehensive metabolic panel) and B12 level as ordered by the physician for 1 of 5 residents reviewed for unnecessary medications (Resident #8). Findings included: 1. Resident #51 was admitted to the facility on 6/17/15 with multiple diagnoses including Chronic Obstructive Pulmonary Disease (COPD). The significant change in status Minimum Data Set (MDS) assessment dated 5/2/16 indicated that Resident #51's cognition was intact. The care plan dated 5/2/16 for Resident #51 was reviewed. There was no care plan that the resident was assessed for self - administration of medication. On 5/16/16 at 8:20 AM, Resident #51 was observed in bed. There was a medicine cup with 2 pills on top of the over the bed table. Resident	F 281	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1) Interventions for affected residents: On 05/31/2016, Resident #51 met with care planning team and reviewed medications. At this time resident will not self medicate. This information was documented in Resident #51 medical record.	6/29/16

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F 281	Continued From page 24 #51 stated that she was asleep and did not know that the nurse had left the pills for her to take. On 5/16/16 at 8:22 AM, Nurse # 1 (unit manager) was interviewed. Nurse #1 stated that nurses were not supposed to leave medications at the resident's bedside. The nurse indicated that he would ask the nurse assigned to Resident #51. On 5/16/16 at 8:30 AM, Nurse # 8 was interviewed. She stated that she was assigned to Resident #51. Nurse #8 denied leaving the medications at bedside. 2. Resident #203 was admitted to the facility on 4/27/16 with multiple diagnoses including Depression. The admission MDS assessment dated 5/4/16 indicated that the resident had moderate cognitive impairment. The care plan dated 5/4/16 for Resident #203 was reviewed. There was no care plan that the resident was assessed for self - administration of medication. On 5/19/16 at 10:15 AM, Resident #203 was observed in his room. There was a medicine cup observed at bedside with a brown liquid medicine in it. Resident #203 indicated that the liquid medicine was for his stomach and nurses had always left his medications for him to take. He added that he would take the medicine later. On 5/19/16 at 4:30 PM, the Director of Nursing (DON) was interviewed. The DON stated that the nurses could leave the medications at the resident's bedside if the resident was able to take the medications by herself/himself. 3. Resident #8 was admitted to the facility on 11/25/11 with multiple diagnoses including schizoaffective disorder (mental condition that causes both a loss of contact with reality and mood problems), chronic pain syndrome,	F 281	On 06/10/2016, Resident #203 left the facility against medical advice. A self administration review was not completed. By 06/29/16, Nurse #8 will be educated by the facility Staff Development Coordinator or Regional Clinical Director on proper administration of medications with emphasis on not leaving medications at the resident bedside. On 5/27/16, Resident #8 had ordered lab completed. Lab results were reported to the physician on 05/27/16. Ordered labs were within normal limits therefore no new orders were required from the physician. 2) Interventions for residents identified as having the potential to be affected: On 06/24/16, an audit will be conducted by the pharmacy consultant for appropriate lab orders. Any pharmacy recommendations for labs received will be communicated to the Physician and processed by the Unit Managers by 06/29/16. On 06/09/16, the facility Unit Managers completed an audit to assess residents for possible self-medication administration. After audit completion, no residents were candidates for self administration of medications. On 06/16/16, Unit Managers and Licensed Nurses began auditing current orders for labs. After audit completion, any necessary labs will be obtained and	

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F 281	Continued From page 25 depression and hypothyroidism. The Quarterly Minimum Data Set assessment dated 2/8/16 indicated Resident #8 was severely impaired in cognition. The May physician ' s orders for Resident #8 was reviewed. The following medications were ordered: meloxicam (nonsteroidal anti-inflammatory drug) 15 milligrams daily, Seroquel (anti-psychotic drug) 200 milligrams once a day and 400 milligrams at 9:00PM nightly, B12 1000 micrograms by mouth one time monthly and divalproex (used to treat certain psychiatric conditions) 600 milligrams three times daily. The orders included an order for CBC, CMP and B12 to be done every 6 months (April/ October). A review of the medical record was conducted. No laboratory results for CBC, CMP and B12 were noted for April, 2016. On 5/19/16 at 1:00PM, the divisional clinical director stated she was unable to find any laboratory results for a CBC, CMP and B12 for April 2016 and, therefore, must not have been obtained. It was unknown if the blood work had been obtained in October. On 5/19/16 at 2:00PM, an interview was conducted with the physician who stated she expected staff to obtain labs as ordered. On 5/19/16 at 4:30PM, the Director of Nursing was interviewed and stated she expected nursing staff to obtain labs as ordered by the physician.	F 281	results communicated to the Physician by 06/24/16. Medical records will file lab results upon completion of physician notification. 3) Systemic Change Licensed Nurses (across all shifts including weekend and as needed (PRN)scheduled) will be re-educated by the facility Staff Development Coordinator or Regional Clinical Director by 06/29/2016 regarding proper administration of medications and orders for lab work. Newly hired Licensed Nurses will be educated during their orientation period by the facility Staff Development Coordinator regarding proper administration of medications and orders for lab work. A Lab order forms binder will be placed at the nurse stations. For all residents with orders for labs, Night Shift (11p-7a) Licensed Nurses will review lab audit sheet nightly ongoing to ensure ordered labs are scheduled and completed as per physician order. Unit Managers will review lab audit sheet on a weekly basis for three months to ensure labs are scheduled and completed as per physician order. Any issues identified will be reporter to the Director of Nursing for evaluation. If a resident desires self administration of medications, a self administration evaluation will be completed by the	

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F 281	Continued From page 26	F 281	Licensed Nurse within 48 hours. This evaluation will be documented in the resident medical record. A review of the resident self administration evaluation will be completed by the Interdisciplinary Team (IDT)within 5 business to determine appropriateness of resident self administration of medication. If the resident self administration evaluation is determined to be appropriate; the resident care plan will be updated accordingly. The Director of Nursing, Unit Manager or Weekend Supervisor will perform facility observations during scheduled medication passes. These observations will occur across all shifts including weekends. Observations will be completed twice weekly for three (3) months to ensure medications are not left at the bedside. 4) Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three(3) months, the DON will report lab audit findings and facility observations to ensure medications are not left at bedside to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312		6/29/16

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F 312	Continued From page 27 A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to provide shower and nail care and failed to provide toileting and feeding assistance for 5 (Residents # 24, #62, #122, #104 & #35) of 6 sampled residents who were dependent or needed extensive assistance with personal hygiene, toileting and eating. The findings included: 1. Resident #35 was admitted to the facility on 2/12/16 and readmitted 4/21/16 with multiple diagnoses including paraplegia, a history of pressure ulcer, muscle weakness and depression. The Minimum Data Set (MDS) dated 2/19/16 indicated the resident was assessed as being cognitively intact. The MDS indicated the resident was assessed with adequate vision and was not assessed with behavioral symptoms. The MDS indicated the resident required extensive assistance with one person physical assist for toileting. The MDS indicated the resident was frequently incontinent of urine. The Plan of Care dated 2/15/16 and revised on 2/25/16 and 5/5/16 indicated the resident had the potential for impaired skin integrity related to decreased mobility and frequent bladder	F 312	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1) Interventions for affected residents: Resident #35 was discharged to the hospital on 05/26/16. Resident #24 under hospice care expired on 05/26/16. On 5/19/16, Residents #62, #104 and #122 had activities of daily (ADL) needs assessed by the Unit Manager and care provided to ensure proper ADL care. ADL care provided including personal hygiene, bathing, nail care and oral care.	

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incontinence. The interventions included to provide incontinence care as needed.

An interview was conducted with Resident #35 on 5/18/16 at 12:00 PM. The resident stated he had not been checked for incontinence since 5:00 AM that morning. He stated he was not aware of when he experienced episodes of incontinence. Resident #35 stated his sitters had checked him for wetness at different times and informed the staff when incontinence care was needed, but were not responsible for checking him for wetness. He stated the staff was responsible for checking him for wetness and performing incontinence care as needed. He stated the first shift nursing assistant had entered his room to deliver and pick up his breakfast tray that morning, but had not checked him for wetness. The resident stated that his sitter was not present in his room at 5:00 AM that morning. He stated the sitter had come in around 8:30 AM. He stated the sitter has come in at different times and has not come every day. The resident stated staff had not checked him for wetness on another day for approximately 12 hours.

A clock was observed to be hanging on the wall of the resident ' s room on 5/18/16 at 12:00 PM.

An interview was conducted with Nursing Assistant (NA) #1 on 5/18/16 at 12:15PM. NA #1 stated the resident was not aware of when he experienced episodes of incontinence. NA #1 stated she was expected to round on the residents every 2 hours. NA#1 stated she had not been checking the resident for wetness. She was depending on his paid sitters to let her know when he needed to have his incontinence brief changed. NA #1 stated she believed the sitters

2) Interventions for residents identified as having the potential to be affected:

An in-service will be conducted by the Staff Development Coordinator or Regional Clinical Director with all Licensed Nurses and Nurse Aides (across all shifts including weekend and as needed (PRN) scheduled) to review assistance with activities of daily (ADL) care including ensuring appropriate toileting, personal hygiene, showers and eating. Residents will be offered assistance with toileting during regular rounds. Nails to be checked with daily care for cleanliness and length. Nurse Aides to notify licensed nurse if nails need trimming. Showers will be given as scheduled and refusals will be reported to the Licensed Nurse. This in-service will be completed by 06/29/16.

Newly hired Licensed Nurses and Nurse Aides will be educated during their orientation period by the Staff Development Coordinator on assistance with activities of daily (ADL) care including ensuring appropriate toileting, personal hygiene, showers and eating.

On 06/16/16, Resident kardex reviews were performed by the facility Unit Manager and Regional Clinical Director to assure documented cares needs of the residents. After review, no kardex updates were required.

3) Systemic Change

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were responsible for performing incontinence care, therefore she was not checking the resident for wetness every 2 hours.

NA #1 was observed performing incontinence care for Resident #35 on 5/18/16 at 12:30 PM. The incontinence brief taken off of the resident was observed to be saturated with urine. No ring was observed on the incontinence brief. No redness of the skin was observed. The draw sheet and bottom sheet were observed to be wet.

An interview was conducted with the Director of Nursing (DON) on 5/19/16 at 4:20 PM. The DON stated she expected the staff to check the residents for incontinence every two to three hours.

2a. Resident #24 was admitted to the facility on 2/11/16 with multiple diagnoses including dementia. The admission MDS assessment dated 2/18/16 indicated that Resident #24 had moderate cognitive impairment and was dependent on the staff with personal hygiene. The assessment also indicated that Resident #24 had not exhibited any behavior of rejecting to care.
The care plan dated 2/18/16 for Resident #24 was reviewed. One of the care plan problems was that Resident #24 had a deficit with activity of daily living (ADL) due to decrease activity tolerance. The goal was for the resident to receive ADL assistance through the next review date. The approaches included to provide extensive assistance as needed for bathing, dressing and personal hygiene.
On 5/16/16 at 3:22 PM, Resident #24 was observed in bed. Her eyes were matted.
On 5/16/16 at 3:24 PM, NA (nurse aide) #4 was

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Scheduled Administrative Staff, Licensed Nurses and Nurse Aides will participate in tray service to residents. An overhead page will be utilized to alert staff of arrival of trays to a particular hall or dining room. Assistance with dining will not be interrupted except for in case of emergencies. Meal assistance as outlined in the resident care plan will be provided to residents by Licensed Nurses and Nurse Aides.

The Director of Nursing will revise the facility shower schedule by 06/24/16. Showers will be documented by the Nurse Aide upon completion in the resident medical record. Refusal of showers will be immediately reported to the Licensed Nurse. During the scheduled shift, the Nurse Aide and License Nurse will follow-up with the resident and offer shower later in the shift if resident desires.

Observation rounds to audit ADL care will be completed by the Unit Manager, Director of Nursing or Nurse Supervisor. Observation rounds will occur daily for four(4) weeks, then three(3) times weekly for eight(8) weeks. These observation rounds will occur across all shifts including weekends and nights.

ADL documentation (including showers) will be audited in morning meeting by the Unit Manager, Director of Nursing or Nurse Supervisor weekly for three(3) months. Licensed Nurses will audit ADL documentation (including showers) prior

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interviewed. NA #4 stated that she had provided morning care to the resident but she did not wash the resident ' s face because the resident had refused.
On 5/17/16 at 1:45 PM, Resident #24 was observed in bed. Her eyes were matted.
On 5/17/16 at 1:50 PM, NA #8 assigned to Resident #24 was interviewed. The NA indicated that she was assigned to the central supply but she was pulled to work on the floor today around 8:30 AM. She was told by the night shift NA who worked from another nursing facility that Resident #24 did not need morning care.
On 5/19/16 at 4:25 PM, the Director of Nursing (DON) was interviewed. The DON indicated that she expected the NAs to inform the nurse or the administrative staff if the resident continued to refuse care.

2b. Resident #24 was admitted to the facility on 2/11/16 with multiple diagnoses including dementia. The admission MDS assessment dated 2/18/16 indicated that Resident #24 had moderate cognitive impairment and needed extensive assistance with eating. The assessment also indicated that Resident #24 had not exhibited any behavior of rejecting to care.
The care plan dated 2/18/16 for Resident #24 was reviewed. One of the care plan problems was that Resident #24 had a deficit with activity of daily living (ADL) due to decrease activity tolerance. The goal was for the resident to receive ADL assistance through the next review date. The approaches included to " provide set up and cueing for all meals seated in wheelchair, she may need more assistance if still in bed " .
The facility ' s meal tray distribution times were reviewed. The lunch time started at 12:15 PM and ended at 1:00 PM.

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to each shift end to ensure complete documentation of ADL care performed.

Department Managers who are assigned "Guardian Angels" will complete care rounds daily ongoing(Monday-Friday). Rounds will focus on resident care to include ensuring appropriate ADL care of the resident. Any identified concerns will be reported in the facility morning meeting with follow-up by the Unit Manager or Director of Nursing. Weekend Supervisor or Manager on Duty will complete care rounds to assess ADL care daily on the weekends ongoing.

4) Monitoring of the change to sustain system compliance ongoing:

Monthly for a minimum of three months, the DON will report observation rounds and ADL documentation audits to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.

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F 312	Continued From page 31 On 5/17/16 at 2:00 PM, Resident #24 was observed in bed. NA #8 (assigned to the resident) indicated that she did not feed or had served the lunch tray for the resident. She indicated that Nurse #4 might have fed the resident. On 5/17/16 at 2:48 PM, Nurse #4 was interviewed. Nurse #4 stated that she did not feed or had served the lunch tray for the resident. She indicated that Nurse #5 (nurse from another nursing facility) might have fed the resident. On 5/17/16 at 2:50 PM, Nurse #5 was interviewed. Nurse #5 stated that he did not feed or had served the lunch tray for the resident. On 5/19/16 at 4:25 PM, the Director of Nursing (DON) was interviewed. The DON indicated that she expected the staff to feed the resident within 30 minutes after the tray was served. 3. Resident # 62 was admitted to the facility on 11/17/10 with multiple diagnoses including dementia. The annual MDS assessment dated 3/24/16 indicated that Resident #62 had memory and decision making problems and needed extensive assistance with eating. The care plan dated 3/22/16 was reviewed. One of the care plan problems was at risk for nutritional decline related to dementia. The approaches included to provide feeding/dining assistance as needed. The facility ' s meal tray distribution times were reviewed. The lunch time started at 12:15 PM and ended at 1:00 PM. On 5/15/16 starting at 1:30 PM, dining observation was conducted. At 3:43 PM, NA #6 was observed to serve the lunch tray in front of Resident #62 and left the room. NA #6 stated that she did not know as to why the resident ' s lunch tray was served late. On 5/15/16 at 4:00 PM, NA #7 was interviewed.	F 312		

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She stated that they had to get the resident up and dressed and that was the reason why her lunch was late.
On 5/15/17 at 4:10 PM, NA #6 was observed to come back to Resident #62 ' s room to feed her.

On 5/19/16 at 4:25 PM, the Director of Nursing (DON) was interviewed. The DON indicated that she expected the staff to feed the resident within 30 minutes after the tray was served.

4. Resident #104 was admitted to the facility on 9/15/15 with multiple diagnoses including Parkinson's disease, heart failure, and muscle weakness.

The quarterly Minimum Data Set (MDS) assessment dated 3/17/16 indicated Resident #104 was cognitively intact, she required extensive assistance with bed mobility, transfers, locomotion on and off the unit, dressing, eating, toilet use, and personal hygiene. Resident #104 required the physical assistance of one person for bathing, she was not steady with balance and was only able to stabilize with staff assistance during transitions and walking.

The care plan for Resident #104 was reviewed. Resident #104 had a care plan for the focus area of Activities of Daily Living (ADLs) self-care deficit related to Parkinson's disease and debility as evidenced by decreased strength and stiffness. The interventions included, in part: "Provide extensive assistance as needed with bathing, dressing, and personal hygiene; perform activity as needed for fatigue, safety. "

An interview was conducted with Resident #104 on 5/16/16 at 4:00 PM. She indicated that she

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was unable to shower independently. She stated that her showers were scheduled for twice a week. She revealed there were times she had not received her shower twice a week. Resident #104 stated that staff had informed her that they were unable to assist her with her shower as scheduled because they didn't have time. She indicated that this had occurred on more than one occasion with more than one staff member. She additionally stated that staff had told her she missed her shower when she asked them to receive it. Resident #104 was unable to report the names of any specific staff members or any specific dates when she had not received her shower as scheduled.

An interview was conducted with the Director of Nursing (DON) on 5/19/16 at 1:40 PM. She indicated that Nursing Assistants (NAs) did not document when showers were given to residents. She indicated that there was no way to see how many showers a specific resident had received during a specified time period without asking every NA who had worked with that resident over that period of time if they remembered if the resident received a shower.

An interview was conducted with NA #3 on 5/19/16 at 1:50 PM. She indicated there had been times when she had to "push" a resident's shower to another day if the facility was short of staff and she had not had time to complete the scheduled shower. NA #3 indicated this had happened on more than one occasion. She was unable to provide any specific dates.

A follow up interview was conducted with the DON on 5/19/16 at 5:00 PM. She stated that her expectation was for showers to be completed as

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scheduled. She indicated that the facility was in the process of implementing a system to document shower completion.

5. Resident # 122 was admitted to the facility on 11/19/14 and readmitted on 4/9/16 with multiple diagnoses including cerebrovascular accident (CVA) and hemiplegia (paralysis) affecting the right dominant side.

A Significant Change Minimum Data Set (MDS) dated 10/4/15 indicated Resident #122 was moderately impaired on cognition. He required extensive assistance with personal hygiene and was totally dependent on staff for bathing.

A Quarterly MDS dated 4/4/16 indicated Resident #122 was moderately impaired in cognition. He required extensive assistance with personal care and bathing.

Resident #122's care plan was reviewed and indicated Resident #122 required assistance with ADL care related to impaired mobility. Staff was to assist resident with bathing, dressing and personal care.

On 5/16/16 at 12:08 PM during stage 1 interview, Resident #122 was observed to have elongated fingernails approximately ¼ inch in length on all fingers. Black material was noted under all of the nails. Resident #122 stated his fingernails were too long and he would rather keep them short.

On 5/18/16 at 12:45PM, an observation of Resident #122 was conducted. Resident #122 was observed to have elongated fingernails approximately ¼ inch in length on all fingers.

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F 312	Continued From page 35 Black material was noted under all of the nails. On 5/18/2016 at 12:48 PM, an interview was conducted with NA#2. He stated he had just completed morning care for Resident #122. He stated morning care for Resident #122 included bathing, shaving if needed, brushing his teeth and washing his hands between his fingers. He said he would use an orange stick and clean under the fingernails if necessary. NA#2 stated he had never trimmed Resident #122's fingernails and had never informed anyone that his fingernails needed to be trimmed. NA #2 observed Resident #122's hands and stated the fingernails should have been cleaned and needed to be trimmed. He said he would tell the nurse. On 5/19/16 at 4:13PM, an interview was conducted with the Director of Nursing who stated she expected morning care to include cleaning the fingernails. Nursing assistants should inform the licensed staff if fingernails needed to be trimmed.	F 312		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced	F 314		6/29/16

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F 314	Continued From page 36 by: Based on record review, observation, resident and staff interview, the facility failed to perform a comprehensive weekly skin and wound assessments of the pressure ulcers, failed to treat pressure ulcers as ordered and failed to obtain orders for the treatment of ischial, calf and right heel ulcers. The facility also failed to turn and reposition residents and failed to properly adjust the setting of the air mattress for 3 (Residents #35, #24 & #105) of 3 sampled residents with pressure ulcers. The findings included: 1a. Resident #35 was admitted to the facility on 2/12/16 and readmitted 4/21/16 with multiple diagnoses including paraplegia, history of pressure ulcers, history of osteomyelitis, muscle weakness and depression. The Admission Minimum Data Set (MDS) dated 2/19/16 indicated the resident was assessed as being cognitively intact. The MDS indicated the resident was assessed with adequate vision and was not assessed with behavioral symptoms. The MDS indicated the resident was assessed with one stage 2 pressure ulcer, one stage 3 pressure ulcer and one stage 4 pressure ulcer present upon admission to the facility. The Plan of Care dated 2/15/16 and revised on 2/25/16 and on 5/5/16 indicated the resident was assessed with pressure ulcers on the sacrum, left lateral lower leg, right gluteal crease and left inner ankle. The goal for the right gluteal crease was that the wound would have signs of resolution through the next review date of 8/3/16. The interventions included to notify the physician as needed for worsening condition of a wound or the	F 314	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1) Interventions for affected residents: Resident #35 is discharged. Resident #24 is discharged. Resident #105 was discharged to the hospital for abnormal labs on 06/09/16. Resident #24 mattress settings were immediately checked and adjusted for the resident correct weight by the Director of Nursing on 5/18/16. 2) Interventions for residents identified as having the potential to be affected: Skin assessments will be performed by the facility Unit Manager, Director of Nursing, Wound Care Nurse, licensed nurses and Nursing Supervisors on in-house residents to visually validate all skin integrity issues are identified and	

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lack of improvement and to administer treatments as ordered by the physician.

The Weekly Pressure Ulcer Log dated 3/4/16 indicated the resident was assessed with a stage 2 pressure ulcer on the ischium (the lower and back part of the hip bone). The ulcer measured 3.0 centimeters (cm) length x 2.0 cm width x 0.1 cm depth. The log dated 3/25/16 indicated the resident was assessed with a stage 2 pressure ulcer on the ischium. The ulcer measured 3.0 cm length x 2.0 cm width x 0.1 cm depth. The log dated 3/30/16 indicated the resident was assessed with a stage 2 pressure ulcer on the ischium. The ulcer measured 3.0 cm length x 2.0 cm width x 0.1 cm depth.

A nurses ' note dated 4/11/16 stated the resident was sent to the emergency room for evaluation due to altered mental status, lethargy and hypotension.

The MDS dated 4/21/16 indicated the resident was readmitted to the facility on 4/21/16. A review of the hospital discharge summary dated 4/21/16 was conducted. The right ischial pressure ulcer was not mentioned in the discharge summary.

A review of the Treatment Administration Record (TAR) dated 4/1/16 to 4/30/16 was conducted. No treatment to the right ischium was ordered or documented as administered.

The Weekly Pressure Ulcer Log dated 4/21/16 indicated the resident was identified with a pressure ulcer on the right ischium. The stage and the measurements of the pressure ulcer were not documented. The log dated 4/27/16

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have appropriate interventions and treatment. These skin assessments will be completed by 06/29/16.

Beginning on 05/26/16 to 5/29/16, the facility Wound Care Nurse and Wound Physician evaluated treatments for residents with pressure for appropriateness and care interventions. During these rounds licensed staff caring for residents were interviewed for any input as deemed necessary by wound practitioner. After evaluation, treatments and interventions were changed as needed and documentation was placed in the resident medical record and care plans were updated. Wound nurse will follow up with weekly evaluations of residents with pressure ulcers.

On 06/07/16, all current residents with air mattresses were audited by the facility Wound Care Nurse. Audit was completed to ensure air mattress settings were adjusted/set per manufacturer guidelines. After audit completed, no additional issues were identified.

3) Systemic Change:
Licensed Nurses will perform resident skin assessments upon all new admissions and weekly. This will include ensuring skin assessments are completed on residents admitted after hours and on weekends. These skin assessments will be documented in the resident medical record. A follow-up skin assessment will be completed on all new admissions by the facility Wound Nurse and documented

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indicated the resident was assessed with a stage 4 pressure ulcer on the ischium. The ulcer measured 7.3 cm length x 6.4 cm width.

A Nurses ' Note dated 5/4/16 stated the resident was assessed by the Wound Physician and a new treatment order for the right gluteal crease for silver alginate and a dry dressing was obtained.

A review of the Physician Orders revealed an order dated 5/5/16 which stated to cleanse wound to the right gluteal crease with normal saline, pat dry, apply silver alginate, cover with dry dressing, secure with paper tape once daily and as needed every day shift for wound.

The Weekly Pressure Ulcer Log dated 5/11/16 indicated the resident was assessed with a pressure ulcer on the ischium. The stage of the pressure ulcer was not documented. The ulcer measured 6.0 cm length x 6.0 cm width.

A review of the Physician Orders revealed an order dated 5/11/16 which stated to discontinue order to cleanse wound to the right gluteal crease with normal saline, pat dry, apply silver alginate, cover with dry dressing, secure with paper tape once daily and as needed every day shift for wound.

A review of the Physician Orders revealed an order dated 5/11/16 which stated to apply Santyl ointment 250 units per gram to the right ischial wound topically one time a day. Cover with calcium and secure with foam dressings at 10:00 AM.

The Wound Care Specialist Evaluation dated

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in the resident medical record. Nurse Aides will check resident skin daily during activities of daily living (ADL) care and notify the Licensed Nurse of any skin issues.

During daily clinical meeting the Director of Nursing, Unit Manager or Nurse Supervisor will audit residents admitted with pressure ulcers to ensure appropriate treatment, care plan interventions, a Braden Scale completed, and registered dietician assessment.

Licensed nurses (across all shifts including weekend and as needed (PRN) scheduled) will be re-inserviced by Staff Development Coordinator or Regional Clinical Director regarding pressure ulcer development and prevention, identification, treatment, checking mattresses for appropriate setting, and reporting new skin areas to the Physician and responsible party. This education will be completed by 06/29/16.

Newly hired Licensed Nurses will be educated during their orientation period by the facility Staff Development Coordinator regarding pressure ulcer development and prevention, identification, treatment, checking mattresses for appropriate setting, and reporting new skin areas to the Physician and responsible party. Education will also include ensuring supervision of care provided by Nurse Aides by monitoring turning and repositioning as well as incontinence checks during routine rounds

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F 314	Continued From page 39 5/11/16 revealed an initial evaluation of an unstageable pressure ulcer of the right ischium was done by the physician. The ulcer measured 6.0 cm length x 5.5 cm width. The depth was not measurable. The assessment stated the ulcer of the right ischium was acquired during a recent hospital admission on 4/21/16. A review of the TAR dated 5/1/16 to 5/31/16 was conducted. The treatment to the right ischial wound was not administered on 5/13/16 and 5/16/16 as ordered by the physician. Nurse #1 was observed performing wound care for Resident #35 on 5/17/16 at 4:50 PM. The right ischial wound was observed to be an unstageable wound due to the presence of slough. The wound was cleaned with normal saline, Santyl was applied to the wound. The wound was covered with a calcium alginate foam dressing. An interview was conducted with Resident #35 on 5/18/16 at 12:00 PM. The resident stated the staff had performed wound treatments daily. The resident stated he had not been checked for incontinence since 5:00 AM that morning. He stated the last time incontinence care was performed for him was at 5:00 AM that morning. He stated he was not aware of when he experienced episodes of incontinence. The resident stated he laid in wet diaper on another day for approximately 12 hours. The resident stated he believed that allowing him to remain in a wet diaper had caused his wounds to become worse. The resident stated he had paid sitters in his room. The sitters had days off and were not present every day. The resident stated it was not their responsibility to check him for wetness.	F 314	Nurse Aides (across all shifts including weekend and as needed (PRN) scheduled) will be re-inserviced by Staff development Coordinator or Regional Clinical Director regarding pressure ulcer development, prevention, and reporting of any new skin areas to the Licensed Nurse. All changes in skin conditions to be immediately reported by the Nurse Aide to Licensed Nurse. This education will be completed by 06/29/16. Newly hired Nurse Aides will be educated by the facility Staff Development Coordinator during their orientation period regarding pressure ulcer development, prevention, and reporting of any new skin areas to the Licensed Nurse. All changes in skin conditions to be immediately reported by the Nurse Aide to Licensed Nurse. Licensed Nurses and Unit Managers (across all shifts including weekend and as needed (PRN) scheduled) will be re-inserviced by the Staff Development Coordinator or Regional Clinical Director to supervise care provided by Nurse Aides by monitoring turning and repositioning as well as incontinece checks during routine rounds. This education will be completed by 06/29/16. The facility Wound Nurse and Director of Nursing will utilize the wound log to track and trend residents with pressure ulcers. Air mattress settings will checked by the	

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A clock was observed to be hanging on the wall of the resident ' s room on 5/18/16 at 12:00 PM.

An interview was conducted with Nursing Assistant (NA) #1 on 5/18/16 at 12:15PM. NA #1 stated the resident was not aware of when he experienced episodes of incontinence. NA #1 stated she was expected to round on the residents every 2 hours. NA#1 stated she had not been checking the resident for wetness. She was depending on his paid sitters to let her know when he needed to have his diaper changed. She believed that the sitters were performing incontinence care on the resident.

NA #1 was observed performing incontinence care for Resident #35 on 5/18/16 at 12:30 PM. The diaper taken off of the resident was observed to be saturated with urine. The draw sheet and bottom sheet were observed to be wet. The ulcer on the right ischium was not covered with a dressing.

An interview was conducted with the Wound Care Physician on 5/18/16 at 1:30 PM. The Physician stated the right ischial wound was acquired at the hospital. The Physician stated that all of the resident ' s existing wounds had deteriorated while admitted to the hospital. She stated she expected the facility to administer the wound treatments as ordered. The Physician stated the resident remaining in a diaper saturated with urine from 5:00 AM to 12:30 PM could have resulted in a worsening of his wounds.

An interview was conducted with NA #1 on 5/19/16 at 3:43 PM. NA #1 state she had found the resident to be in need of incontinence care three times during the shift.

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Licensed Nurse every shift and confirmation of correct settings will be documented in the resident medical record.

Observation rounds will be completed by the facility Director of Nursing, Unit Manager or Nurse Supervisor daily for three(3) months to validate compliance of interventions to prevent pressure ulcer development.

Licensed nurses will complete Braden Scale on admission and weekly for four (4) weeks.

4) Monitoring of the change to sustain system compliance ongoing:

Focus resident at risk meeting will be held weekly with Interdisciplinary Care Team to review residents with pressure ulcers or at risk for developing pressure ulcers.

Monthly for a minimum of three months, the DON will report weekly pressure ulcer audits to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.

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An interview was conducted with the Director of Nursing (DON) on 5/19/16 at 4:20 PM. The DON stated she expected the staff to check the residents for incontinence every two to three hours. The DON stated she expected the resident ' s wound treatments to be administered during the 7:00 AM to 3:00 PM shift. The DON stated to her knowledge, the resident received wet to dry dressing changes to the right ischial wound every day after his readmission from the hospital on 4/21/16. She stated there was no order written for the wet to dry dressings to the right ischium and there was no documentation of the administration of the wet to dry dressings. The DON did not offer an explanation as to why an order for a wound treatment was not obtained for the right ischium after the resident was readmitted to the facility on 4/21/16.

1b. Resident #35 was admitted to the facility on 2/12/16 and readmitted 4/21/16 with multiple diagnoses including paraplegia, history of pressure ulcers, history of osteomyelitis, muscle weakness and depression.

The Admission Minimum Data Set (MDS) dated 2/19/16 indicated the resident was assessed as being cognitively intact. The MDS indicated the resident was assessed with one stage 2 pressure ulcer, one stage 3 pressure ulcer and one stage 4 pressure ulcer present upon admission to the facility.

The Plan of Care dated 2/15/16 and revised on 2/25/16 and on 5/5/16 indicated the resident was assessed with pressure ulcers on the sacrum, left

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lateral lower leg, right gluteal crease and left inner ankle. The goal for the left lateral calf pressure ulcer was that the wound would have signs of resolution through the next review date of 8/3/16. The interventions included to notify the physician as needed for worsening condition of a wound or the lack of improvement and to administer treatments as ordered by the physician.

A review of the Wound Care Specialist Evaluation dated 2/24/16 indicated the left posterior shin pressure ulcer was assessed as a stage 3 and measured 3.0 cm length x 1.0 cm width x 0.3 cm depth.

A review of the Physician Orders revealed an order dated 3/24/16 stated clean wound to left calf with normal saline, apply Santyl and calcium alginate and secure with island wound dressing till healed one time a day.

The Weekly Pressure Ulcer Log dated 3/30/16 indicated the resident was assessed with a pressure ulcer stage 4 pressure ulcer on the left calf. The ulcer measured 8.0 cm length x 4.0 cm width x 0.5 cm depth.

A review of the Physician Orders revealed an order dated 4/6/16 stated to discontinue order to clean wound to left calf with normal saline, apply Santyl and calcium alginate and secure with island wound dressing till healed one time a day. An order dated 4/6/16 stated to clean wound to left calf with a wound cleanser, apply silver alginate dressing and secure with kerlix one time a day.

A nurses ' note dated 4/11/16 stated the resident was sent to the emergency room for evaluation

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F 314	Continued From page 43 due to altered mental status, lethargy and hypotension. The MDS dated 4/21/16 indicated the resident was readmitted to the facility on 4/21/16. The hospital discharge instructions dated 4/21/16 stated the L shin wound was to be treated with normal saline moist dressings twice a day. The Weekly Pressure Ulcer Log dated 4/21/16 indicated the resident was assessed with a pressure ulcer on the left calf. The stage and measurements of the pressure ulcer were not documented. The Weekly Pressure Ulcer Log dated 4/27/16 indicated the resident was assessed with a pressure ulcer stage 4 pressure ulcer on the left calf. The ulcer measured 13.1 cm length x 13.1 cm width x 0.8 cm depth. A review of the TAR dated 4/1/16 to 4/30/16 revealed the treatments to the left calf were administered as ordered by the physician until the resident was discharged to the hospital on 4/11/16. There was no documented treatment or orders for treatment to the left calf from 4/21/16 until 4/30/16. A review of the Physician ' s Orders revealed an order dated 5/5/16 which stated to cleanse the posterior calf to the left leg with normal saline, pat dry and apply silver alginate, cover with dry dressing and secure with paper tape once daily and as needed every day shift. A review of the TAR dated 5/1/16 to 5/31/16 revealed there was no documented treatment or orders for treatment to the left calf from 5/1/16 until 5/4/16. The treatment order dated 5/5/16	F 314		

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which stated to cleanse the posterior calf to the left leg with normal saline, pat dry and apply silver alginate, cover with dry dressing and secure with paper tape once daily was not documented as administered on 5/11/16, 5/13/16 and 5/16/16.

Nurse #1 was observed performing wound care for Resident #35 on 5/17/16 at 4:50 PM. The left shin wound was observed to be a stage 4 wound with granulation tissue. The wound was cleaned with normal saline, treated with silver alginate and covered with a foam dressing.

An interview was conducted with Nurse #1 on 5/17/16 at 5:30 PM. Nurse #1 stated he did not administer the wound treatment as ordered until 4:50 PM because he was busy doing other dressing changes throughout the day. Nurse #1 stated he normally administered the wound treatments for Resident #35 earlier in the day.

An interview was conducted with Resident #35 on 5/18/16 at 12:00 PM. The resident stated the staff had performed wound treatments daily

An interview was conducted with the Director of Nursing (DON) on 5/19/16 at 4:20 PM. The DON stated to her knowledge, the resident received wet to dry dressing changes to the left calf pressure ulcer every day after his readmission from the hospital on 4/21/16 until 5/5/16. She stated there was no order written for the wet to dry dressings to the left calf and there was no documentation of the administration of the wet to dry dressings. The DON did not offer an explanation as to why an order for a wound treatment was not obtained for the left calf after the resident was readmitted to the facility on 4/21/16.

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1c. Resident #35 was admitted to the facility on 2/12/16 and readmitted 4/21/16 with multiple diagnoses including paraplegia, history of pressure ulcers, history of osteomyelitis, muscle weakness and depression.

The Admission Minimum Data Set (MDS) dated 2/19/16 indicated the resident was assessed as being cognitively intact. The MDS indicated the resident was assessed with one stage 2 pressure ulcer, one stage 3 pressure ulcer and one stage 4 pressure ulcer present upon admission to the facility.

The Plan of Care dated 2/15/16 and revised on 2/25/16 and on 5/5/16 indicated the resident was assessed with pressure ulcers on the sacrum, left lateral lower leg, right gluteal crease and left inner ankle. The goal for the left lateral calf pressure ulcer was that the wound would have signs of resolution through the next review date of 8/3/16. The interventions included to notify the physician as needed for worsening condition of a wound or the lack of improvement and to administer treatments as ordered by the physician.

A nurses ' note dated 4/11/16 stated the resident was sent to the emergency room for evaluation due to altered mental status, lethargy and hypotension. The MDS dated 4/21/16 indicated the resident was readmitted to the facility on 4/21/16. The hospital discharge instructions stated the right heel ulcer was to be treated with a thin layer of Silvasorb gel to maintain a moist healing environment and to reduce bioburden and to cover with Allevyn for protection. The Weekly Pressure Ulcer Log dated 4/21/16 indicated the resident was assessed with a pressure ulcer on

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the right heel. The stage and measurements of the pressure ulcer were not documented.

The Weekly Pressure Ulcer Log dated 4/27/16 indicated the resident was assessed with an unstageable pressure ulcer on the right heel. The ulcer measured 2.5 cm length x 4.5 cm width.

A review of the TAR dated 4/1/16 to 4/30/16 revealed no documented treatment or orders for treatment to the right heel from 4/21/16 until 4/30/16.

The Wound Care Specialist Evaluation dated 5/4/15 revealed an initial evaluation of an unstageable pressure ulcer to the right heel. The ulcer measured 2.5 cm length x 4.5 cm width.

A review of the Physician ' s Orders revealed an order dated 5/5/16 which stated to cleanse the right heel wound with normal saline, pat dry, apply silver alginate, cover with a dry dressing, secure with paper tape once daily and as needed every day shift.

A review of the TAR dated 5/1/16 to 5/31/16 revealed no documented treatment or orders for treatment to the right heel from 5/1/16 until 5/4/16. The treatment order dated 5/5/16 which stated to cleanse the right heel wound with normal saline, pat dry, apply silver alginate, cover with a dry dressing, secure with paper tape once daily and as needed every day shift was not documented as administered on 5/11/16, 5/13/16 and 5/16/16.

Nurse #1 was observed performing wound care for Resident #35 on 5/17/16 at 4:50 PM. The right heel wound was observed to be unstageable due

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indicated that Resident #24 had moderate cognitive impairment and had 2 unstageable pressure ulcers that were present on admission. The assessment also indicated that the resident needed extensive assistance with bed mobility.

The care plan for Resident #24 was reviewed. The original care plan dated 2/18/16 had addressed the pressure ulcers on the right and left heel. The care plan was revised on 5/2/16 to address the pressure ulcers on the right and left heel and the coccyx. One of the care plan problems was pressure ulcers on the left and right heel and coccyx and potential for impaired skin integrity. The goal was the pressure ulcers will have signs of resolution through the next review date. The approaches included notify the physician as needed for worsening condition of wound or lack of improvement from treatment, skin care and treatment per doctor ' s orders and provide extensive assistance as needed with turning and repositioning.

The nursing progress notes were reviewed for weekly skin checks. The result of the weekly skin check was not documented on a weekly basis as ordered. In March 2016, there was only 1 skin check documented (3/5/16) and there was no new skin issue noted. There were 2 weekly skin checks documented in April, 2016. On April 5, there was no new skin issue noted and on April 27, a stage II ulcer was found on the buttock/sacrum measuring 14 centimeters (cm.) x (by) 11.5 cm. with drainage and was pink and purple in color. The weekly skin check dated May 9 indicated that a stage III pressure ulcer on the buttock/sacrum was found, black in color and with scant drainage noted. There was no measurement documented.

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The wound doctor notes were reviewed. The notes dated 5/11/16 indicated that Resident # 24 had unstageable pressure ulcer to her sacrum measuring 9.5 x 9 cm and it had 90% necrosis. The notes indicated that this was the first time the wound doctor had seen the pressure ulcer on the sacrum.

On 5/16/16, there was a doctor's order to make sure Resident #24 was maintained on her side at all times to help with the healing of the sacral pressure ulcer.

On 5/17/16 at 7:30 AM, Nurse #10 was interviewed. Nurse #10 stated that night shift nurse was responsible for the weekly skin checks/assessments. She added when they were short of nurse aide at night she had to help take care of residents and so she had no time to do her skin checks/assessments.

On 5/17/16 at 3:15 PM, Resident #24 was observed during the dressing change. Nurse # 3 was observed to clean the pressure ulcer on the sacrum with normal saline, Santyl (debriding agent) ointment was applied and covered with Calcium Alginate (antimicrobial) dressing.

On 5/18/16 at 9:15 AM, 10:10 AM and 1:25 PM Resident #24 was observed in bed on her back. The setting of the air mattress was at 120.

On 5/18/16 at 1:30 PM, NA # 5 was interviewed. NA #5 stated that she was pulled from another nursing facility to help and she was assigned to Resident #24. She indicated that she forgot to turn the resident after she gave her a bath this morning.

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On 5/18/16 at 1:37 pm, the wound doctor was interviewed. The wound doctor indicated that the staff had informed her of the pressure ulcer on the sacrum for Resident #24 on 5/11/16. She indicated that the ulcer was big and was covered with necrosis. The wound doctor also indicated that the resident had an air mattress but the air mattress would not help with the wound healing if it was not set properly. She indicated that she had observed the air mattress of Resident #24 set at 400 lbs. and the resident weighed less than 100 lbs. She added that she had informed Nurse # 3 about the incorrect setting of the air mattress.

On 5/18/16 at 3:25 PM, Nurse #1 was interviewed. Nurse #1 stated that it was his responsibility to make wound rounds with the wound doctor on a weekly basis. He confirmed that the wound doctor had brought to his attention the incorrect setting of the resident's air mattress. He indicated that he didn't inform the DON about it. Nurse #1 also stated that the maintenance person was responsible for adjusting the setting of the air mattress. Nurse #1 added that if the nurses were doing the weekly skin checks/assessments, the pressure ulcer on the sacrum of Resident #24 should have been identified earlier.

On 5/18/16 at 5:30 PM, the maintenance person was interviewed. He stated that did not know that it was his responsibility to adjust the setting of the resident's air mattress. He added that the air mattress was set according to the resident's weight and he didn't even know the weights of the residents.

On 5/18/16 at 5:35 PM, the air mattress of

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Resident #24 was observed with Nurse #6. The air mattress was set at 120. Nurse #6 was interviewed. Nurse #6 stated that she didn't check the setting of the air mattress. She added that the maintenance person was responsible in adjusting the setting of the air mattress.

On 5/19/16 at 4:25 PM, the DON was interviewed. The DON indicated that it was the responsibility of the nurses to check the setting of the air mattress daily. The DON indicated that the air mattress should be set according to the resident's weight. She added that Resident #24's weight was 94 lbs. and the air mattress should have been adjusted at 94. The DON also indicated that she expected the staff to turn and reposition residents with pressure ulcers every 2 hours. The DON indicated that the night shift nurses were responsible for the weekly skin checks/assessments and they had initialed the Treatment Administration Records indicating that they had assessed the residents but they were not documenting the results of the assessments and they should.

3. Resident #105 was admitted to the facility on 4/6/16. Cumulative diagnoses included left calcaneal osteomyelitis right heel and left heel foot ulcers.

A pressure wound assessment and care tool dated 4/6/16 indicated Resident #105 had pressure ulcers on the right and left heels. Measurements of the right heel was 5 centimeters (cm) in length x 4.6 cm in width x 1.2 cm in depth at stage 2 (partial thickness loss of tissue presenting as a shallow open ulcer) and left heel measurements of 8cm in length x 5 cm in width x deep to bone at stage 4 (full bone

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exposure).

Admission physician orders dated 4/6/16 stated the following: wound vac (machine used to aid in wound healing) dressing change three times a week and PRN (as needed). Clean wound bed with normal saline. Apply skin sealant to surrounding tissue (skin prep). Cut sponge to wound size and place in wound. Cover with transparent dressing. Attach wound vac at 125mm (millimeters) continuous suction to both right and left heels.

A physician ' s order dated 4/7/16 indicated wound vac dressing changes would occur on Tuesday, Thursday and Saturday and as needed if negative pressure was unable to be restored.

An Admission Minimum Data Set (MDS) dated 4/13/16 indicated Resident #105 was moderately impaired in cognition. He required extensive assistance with bed mobility, transfers (both 2 person), locomotion on and off the unit, dressing and toilet use. Limited assistance was needed with personal hygiene. Supervision was needed with eating. He was frequently incontinent of bladder and bowel. Pressure ulcers were noted as one stage 3 ((full thickness tissue loss) and one stage 4 (full thickness tissue loss with exposed bone, tendon or muscle.

The Care Area Assessment (CAA) for pressure ulcers stated Resident #105 was admitted to facility following a hospitalization related to left calcaneal osteomyelitis, right foot wound (status post orthopedic consult with surgical debridement x 2 removal of all the infected tissue and bones). BKA (bilateral knee amputation) was not recommended per infectious disease consult and

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F 314	Continued From page 53 diagnosis of acute blood loss anemia. Pressure ulcers would be care planned. The pressure wound assessment and care tool dated 4/13/16 indicated the following: left heel pressure ulcer stage 4 measured 5cm in length x 5cm in width x 2 cm in depth with moderate bloody drainage. The right heel pressure ulcer measured 6 cm in length x 5 cm in width x 1 cm in depth at stage 3 with a moderate amount of bloody drainage noted. A care plan last revised on 4/21/16 indicated pressure ulcers on right and left heels. Interventions included: Pressure relief ankle foot orthosis (device worn on the foot to relieve pressure) to both heels when using wound vac. Monitor/ report increased temperature, excessive perspiration/sweating. Notify MD as needed for worsening condition or lack of improvement from treatment. Skin care and treatments per physician order. Wound vac per physician order. Pressure wound assessment and care tool documentation was reviewed and revealed the following: 4/20/16--right heel: 6 cm in length x 5 cm in width x 1 cm depth at stage 3 with moderate bloody drainage; left heel: 5cm in length x 5 cm in width x 2 cm depth at stage 4 with moderate bloody drainage. 4/27/16--right heel: 6cm in length x 5 cm in width x 1 cm depth at stage 3 with moderate bloody drainage; left heel: 5 cm in length x5 cm in width x 2 cm depth at stage 4 with moderate bloody drainage. 5/4/16--right heel: 6 cm in length x 5 cm in width x	F 314		

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1.0 depth with odor and drainage. The left heel measured 5 cm in length x 5 cm in width x 1.0 depth with odor and drainage. There was no further notes or description of the wound bed, type of odor or type of drainage for either pressure ulcer.

5/11/16-- right heel: 5 cm in length x 5 cm in width x 0.5 cm depth; left heel: 5 cm in length x 5 cm in width x 1.0 cm depth. There was no documentation regarding a description of the wound bed, if odor was present or type of drainage for either pressure ulcer.
.
On 5/17/16 at 2:30PM, pressure ulcer care for Resident #105 was observed with nurse #1 and nurse #2. The left heel pressure dressing was intact and continued to be on the wound vac. The right heel had a dressing in place and was not on the wound vac. There was visible blood noted on the outside of the dressing. The dressing was removed and the pressure ulcer was cleansed with normal saline. The wound bed was beefy red with several scattered dark areas of tissue noted. The pressure ulcer measured 4 centimeters in length and 4 centimeters in width and 0.6 centimeters in depth.

On 5/17/16 at 2:45PM, an interview was conducted with nurse #1. He stated he was the person who provided care and applied the wound vac. Nurse #1 stated if the wound vac was removed/ lost negative pressure, the nursing staff would leave him a note, call him or verbally tell him if a wound vac had come off and needed to be replaced. He stated he was not aware that Resident #105 ' s wound vac was off his right heel. He stated both heels should be on the wound vac and he did not know why the right heel

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F 314	Continued From page 55 was not on the wound vac. On 5/18/16 at 2:30PM, an interview was conducted with nurse #1. He stated Resident #105 was not seen by the wound physician that came to the facility but went to an outside wound clinic. He stated he only measured the wounds but did not describe what the wound appearance was or what stage the wound was because he felt that should be done when Resident #105 went to the wound clinic. He stated he had been " on the floor " working as a floor nurse and had not had time to write a wound care note during the month of May, 2016. . On 5/19/16 at 4:13PM, an interview was conducted with the Director of Nursing. She stated she expected the wound vac to remain in place. If the wound vac was removed due to bleeding, the nursing staff should have written a note and called and/or left a note for nurse #1. The Director of Nursing stated there should have been documentation of the bleeding of the pressure ulcer and removal of the wound vac in a nursing note. The wound clinic should have been called and been notified of the bleeding to see if they wanted wound vac replaced. She also stated she expected the weekly wound assessment to include measurements and a description of the wound.	F 314		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate	F 329		6/29/16

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F 329	Continued From page 56 indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff, pharmacist and physician interview, the facility failed to have an adequate indication for the continued use of an antibiotic (Resident #126), failed to monitor the Thyroid Stimulating Hormone (TSH) level for a resident on a thyroid hormone drug (Resident #8) and failed to monitor behaviors for residents on psychotropic medications (Residents #80 & #18) for 4 of 5 sampled residents reviewed for unnecessary medications. Findings included: 1. Resident # 126 was admitted to the facility on 4/13/14 with multiple diagnoses including Congestive Heart Failure (CHF). The annual MDS assessment dated 3/30/16 indicated that Resident #126's cognition was intact and she had received antibiotic medication during the last 7	F 329	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1) Interventions for affected residents:	

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days.
The May 2016 physician's orders for Resident #126 was reviewed. The orders included Nitrofurantoin (an antibiotic drug) 50 milligrams (mgs.) by mouth daily indefinitely for prophylaxis. The order indicated that Nitrofurantoin was started on 3/26/15.
On 5/19/16 at 1:14 PM, the Director of Nursing (DON) was interviewed. The DON indicated that the indication for the use of Nitrofurantoin was for prophylaxis. She further stated that the resident had Urinary Tract Infection (UTI) in the past.
Review of the laboratory results revealed that Resident #126 had urinalysis and urine culture and sensitivity done 4/19/15.
On 5/19/16 at 1:55 PM, the attending physician of Resident #126 was interviewed. She stated that Resident #126 used to have a chronic UTI and Nitrofurantoin was used for prophylaxis. She added that the resident had not had UTI recently so she would write an order to stop the Nitrofurantoin.
On 5/19/16 at 2:45 PM, the pharmacist was interviewed. The pharmacist indicated that Resident #126 had been treated for UTI years ago and was kept on Nitrofurantoin to prevent further UTI. The pharmacist confirmed that he did not address the continued use of the antibiotic with the physician or Director of Nursing.
On 5/19/16 at 4:25 PM, the DON was interviewed and she stated that the physician had ordered to discontinue the Nitrofurantoin as of today (5/19/16).

2. Resident #8 was admitted to the facility on 11/25/11. Cumulative diagnoses included, in part, schizoaffective disorder, hypothyroidism, vitamin D deficiency hypertension and diabetes.

Resident #126 was evaluated by the physician on 05/19/16 and antibiotic was discontinued on 05/19/16.

Resident #8 had lab work completed on 05/27/16 and reviewed by physician on 05/27/16.

Resident #80 is discharged to another skilled nursing facility on 06/01/16.

Resident #18 had behavior monitoring orders added in their electronic medical record (Point Click Care (PCC). Resident #18 will continue with Psych services.

2) Interventions for residents identified as having the potential to be affected:

On 06/09/16, the facility Unit Manager completed an audit on current resident receiving psychoactive medications to ensure behavior monitoring documentation in place and utilized. After review, those residents who needed behavior monitoring had orders added to their electronic medical record.

On 06/09/16, the facility Unit Manager completed an audit on current residents receiving psychoactive medication to evaluate for appropriate diagnosis.

On 06/14/16, the facility Social Services Director and Minimum Data Set(MDS) Nurse completed an audit on current residents on psychoactive medications and behaviors reviewed for appropriate

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A Quarterly Minimum Data Set (MDS) dated 2/8/16 indicated Resident #8 was severely impaired in cognition. Medications received during the look back period included seven (7) days of antipsychotic, antianxiety and antidepressant medication.

The May Physician orders were reviewed. The orders included Levothyroxine (thyroid medication) 25 mcg by mouth daily. There were no orders to monitor the TSH level.

Review of the laboratory results revealed that Resident #8 ' s last TSH level was done on 8/14/14.

On 5/19/16 at 2:00PM, the attending physician of Resident #8 was interviewed. She stated she was unaware that a TSH was not ordered with the routine labs and she would normally have a TSH level done at least yearly.

3. Resident #80 was admitted to the facility on 5/22/15 with multiple diagnoses including anxiety disorder and congestive heart failure. The quarterly Minimum Data Set (MDS) assessment dated 2/26/16 indicated Resident #80 had significant cognitive impairment and received antianxiety medications. No behaviors were documented for Resident #80 during the review period.

The plan of care, dated 1/26/16, indicated Resident #80 had the potential for complications associated with the use of psychotropic medications. The interventions included:
- Monitor/report side effects (examples: drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion,

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care plan. After review, any residents noted on psychoactive medications without care plan had the care plan added to their medical record.

Licensed nurses (across all shifts including weekend and as needed(PRN) scheduled) will be re-educated by the Staff Development Coordinator (SDC) or Regional Clinical Director on importance of monitoring behaviors and documenting in PCC. Education included initiating behavior monitoring in PCC on any newly admitted resident on a psychoactive medication and/or newly ordered psychoactive medication while in facility. This education will be completed by 6/29/16.

Newly hired Licensed Nurses will be educated during their orientation period by the facility Staff Development Coordinator regarding importance of monitoring behaviors and documenting in PCC. Education will include initiating behavior monitoring in PCC on any newly admitted resident on a psychoactive medication and/or newly ordered psychoactive medication while in facility.

Psych Consult orders will be requested from the physician by the Unit Manager, Director of Nursing or Nurse Supervisor for any residents with escalating behaviors to assist with behavior management and medication management.

3) Systemic Change:

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disorientation, depression, dizziness, lightheadedness, impaired thinking/judgment, memory loss, forgetfulness, nausea, stomach upset, blurred/double vision)
- Monitor/report target behavior symptoms (examples: agitation, restlessness, crying)
- Psychiatric consultation as ordered.

A nursing progress note dated 12/3/15 indicated Resident #80 complained of her heart racing and being unable to catch her breath.

A nursing progress note dated 12/3/15 indicated the physician was notified of Resident #80's episode of increased heart rate and increased respirations and ordered PRN Ativan 0.5mg for anxiety. There was no documentation that indicated the use of non-pharmacological behavioral interventions prior to the use of Ativan.

A physician's order dated 12/3/15 for Resident #80 indicated Ativan (antianxiety medication) 0.5 milligrams (mg) every 6 hours as needed (PRN) for anxiety.

A medication administration note dated 12/4/15 indicated Resident #80 presented with increased respirations and crying. PRN Ativan 0.5 mg was administered and was effective for Resident #80.

A medication administration note dated 12/6/15 indicated Resident #80 was agitated. PRN Ativan 0.5 mg was administered and was effective for Resident #80.

A medication administration note dated 12/7/15 indicated Resident #80 had an episode of crying and increased respirations. PRN Ativan 0.5 mg was administered and was effective for Resident

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Monthly for a minimum of three(3) months, an audit will be completed by the Unit Manager or Director of Nursing to ensure behavior management documentation is in place on residents on psychoactive medications.

Focus Interdisciplinary Team (IDT) members include the Director of Nursing, Unit Manager, MDS Nurse and Social Services Director. The Focus IDT will be responsible for reviewing residents on psychoactive medications. Monthly during focus IDT meeting residents on psychoactive medications will be reviewed regarding behavior monitoring, progress notes, diagnosis, medication reviews, attempted gradual dose reduction (GDR), psych notes and appropriate physician orders.

Pharmacy consultant report related to psychoactive medication will be reviewed in monthly QAPI meeting to ensure residents on psychoactive medications are reviewed and monitored. This information will be reported to the QAPI committee by the Director of Nursing monthly.

New admissions will be reviewed during morning clinical meeting by the Unit Manager, Director of Nursing or Nurse Supervisor for psychoactive medications with appropriate diagnosis.

Licensed Nurses will initiate behavior monitoring in PCC on any newly admitted

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#80.

A medication administration note dated 12/11/15 indicated Resident #80 had anxiety and was restless. PRN Ativan 0.5 mg was administered and was effective for Resident #80.

A Medication administration note dated 12/20/15 indicated PRN Ativan 0.5 mg was administered and was effective for Resident #80. There was no documentation of Resident #80 ' s behavioral symptoms for this administration of Ativan.

A medication administration note dated 12/21/15 indicated Resident #80 was agitated, restless, crying, trying to get out of bed, and had increased respirations and heart rate. PRN Ativan 0.5 mg was administered and was effective for Resident #80.

Medication administration notes dated 12/24/15, 12/25/15, 12/26/15, 12/27/15, 1/2/16, 1/5/16, 1/16/16, 1/19/16, 1/29/16, 1/30/16, 2/1/16, 2/6/16, 2/7/16, 2/8/16, 2/9/16, 2/14/16, 2/20/16, 3/6/16, 3/13/16, 4/3/16, 4/16/16, 4/17/16, 4/19/16, 4/20/16, 4/23/16, 4/24/16, 5/1//16, 5/7/16, and 5/8/16 indicated PRN Ativan 0.5 mg was administered and was effective for Resident #80. There was no documentation of Resident #80's behavioral symptoms for the administration of Ativan on these dates.

A medication administration note dated 5/17/16 indicated Resident #80 was chanting, "Oh I ' m gonna die". She had increased respirations and rapid breathing. PRN Ativan 0.5 mg was administered and was effective for Resident #80.

An interview was conducted on 5/18/16 5:35 PM

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resident on a psychoactive medication and/or newly ordered psychoactive medication while in facility.

On 5/24/16, education on use of indefinite antibiotics was provided by the facility Staff Development Coordinator to all Licensed Nurses (across all shifts including weekend and as needed(PRN) scheduled). This education will also be provided to newly hired Licensed Nurses during their orientation period by the Staff Development Coordinator.

On 5/24/16, education on ensuring completion of labs and notification of lab results to MD was provided by the facility Staff Development Coordinator to Licensed Nurses (across all shifts including weekend and as needed(PRN) scheduled). This education will also be provided to newly hired Licensed Nurses during their orientation period by the Staff Development Coordinator.

4) Monitoring of the change to sustain system compliance ongoing:

Weekly for a minimum of three(3) months, the DON will report any issues related to noncompliance with psychoactive medication monitoring to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing;

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F 329	Continued From page 61 with Resident #80. She stated she was feeling good today. She indicated if she had any feelings of nervousness she asked the staff for medicine. She stated the medicine helped. An interview was conducted on 5/18/16 at 10:00 AM with the Director of Nursing (DON). She indicated nursing staff documented behaviors on the behavior monitoring record located on the MAR or in nursing progress notes. She stated she expected observed behaviors to be documented by nurses. She indicated that the behavior monitoring record was expected to be included on the MAR for residents who received antianxiety medications. 4. Resident #18 was admitted to the facility on 3/29/16 with multiple diagnoses including encephalopathy, cognitive communication deficit, major depressive disorder, and mild intellectual disabilities. Resident #18's physician's orders included the antianxiety medication, Klonopin, and the antidepressant medication, Celexa. The social service assessment dated 4/3/16 indicated Resident #18 had rejected care 1 to 3 days since admission and yelled out for the nurse at times. Resident #18 received psychiatric services. Resident #18's admission Minimum Data Set (MDS) assessment dated 4/4/16 indicated his cognition was intact. He was indicated to have rejected care 4-6 days during the review period. Resident #18 was coded as a level II Preadmission Screening and Resident Review (PASRR) with the condition of mental retardation.	F 329	and determine the need for further auditing beyond the three months.	

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F 329	Continued From page 62 The comprehensive care plan for Resident #18 was reviewed. The plans of care for Resident #18 included, in part, the following focus areas: behavior problem related to yelling, agitation; rejection of care as evidenced by non-compliance with getting out of bed; and the potential for complications associated with the use of psychotropic medications. The interventions for the plan of care related to the use of psychotropic medications included the monitoring and reporting of signs and symptoms of depression. The care plan listed the following examples of signs and symptoms of depression: sad, irritable, anger, crying shame, worthlessness, guilt, negative mood/comments, slowed movement, agitation, disrupted sleep, fatigue, lethargy, lack of enjoyment in usual activities, changes in cognition, changes in weight/appetite, anxiety. A physician's order dated 4/11/16 for Resident #18 indicated a referral to mental health services. A nursing progress note dated 4/12/16 indicated a Nursing Assistant informed the nurse that on the previous day (4/11/16) Resident #18 was screaming in his room. The Social Worker (SW) was informed. A care plan meeting note dated 4/18/16 indicated Resident #18 was not participating in therapy, he continued to be administered Celexa, and his behavior of yelling out for the nurse was discussed. A psychiatric progress note dated 4/18/16 indicated nursing staff noted Resident #18 had anxious impulsivity by calling out for care needs rather than using the call bell. Resident #18	F 329		

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F 329	Continued From page 63 called out repeatedly until someone responded. This behavior happened repeatedly. A diagnosis of adjustment reaction with anxiety was added to Resident #18's diagnoses. The psychiatric plan for Resident #18 indicated Klonopin (antianxiety medication) 0.125 mg twice daily targeting anxious calling out behavior. The Nurse Practitioner (NP) indicated Resident #18 was experiencing anxiety at having his needs met after having transitioned to a new facility with new routines. There was no documentation that indicated the use of non-pharmacological behavioral interventions prior to the use of Klonopin. A physician's order dated 4/19/16 for Resident #18 indicated Klonopin 0.125 mg twice daily for anxiety. A nursing progress note dated 4/19/16 indicated Resident #18 was yelling out in his room after having pressed his call light. The call light was answered by the nurse and Resident #18 stated he didn't need help at that time. After the nurse exited the room, Resident #18 began yelling out again. A nursing progress note date 4/19/16 indicated Resident #18 frequently called the nurse to his room. Resident #18 had asked for incontinent care after he had just received care a few minutes prior. Resident #18 was rechecked and was found to be dry. Nursing staff continued to try to make Resident #18 as comfortable as possible. A nursing progress note dated 4/20/16 indicated Resident #18 continued to press the call bell constantly and called out for the nurse. Resident	F 329		

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F 329	Continued From page 64 #18 was provided with incontinent care and shortly after he called out for the nurse again to provide incontinent care. In several instances Resident #18 pressed the call light and when staff checked on him he was found with his eyes closed and deeply asleep. A Physician's Assistant (PA) progress note dated 4/25/16 indicated Resident #18 frequently called out for the nurse. A physician's order dated 4/30/16 for Resident #18 indicated Klonopin 0.125 mg twice daily as needed for increased agitation/yelling out. The May 2016 MAR through 5/17/16 for Resident #18 was reviewed. There was no behavior monitoring record on the May 2016 MAR for Resident #18. A psychiatric progress note dated 5/6/16 indicated nursing staff reported the Klonopin had helped during the daytime, but that around 9:00 PM and later Resident #18 became increasingly impatient and demanding with regard to care needs. The psychiatric plan for Resident #18 indicated a continuation of the morning dose of Klonopin 0.125 mg and an increase in the evening dose of Klonopin to 0.25 mg at 7:00 PM targeting anxiety, impatient and demanding behaviors, and the anxiety underlying those behaviors. A physician's order dated 5/6/16 for Resident #18 indicated the discontinuation of Klonopin 0.125 mg twice daily for anxiety. A physician's order dated 5/6/16 for Resident #18 indicated the discontinuation of Klonopin 0.125 mg twice daily as needed for increased	F 329		

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F 329	Continued From page 65 agitation/yelling out. A physician's order dated 5/6/16 for Resident #18 indicated Klonopin 0.25 mg once daily at 7:00 PM for anxiety. A physician's order dated 5/7/16 for Resident #18 indicated Klonopin 0.125 mg once daily at 9:00 AM for anxiety. An interview was conducted on 5/16/16 11:15 AM with Resident #18. He reported no concerns. Resident #18 was observed with no signs or symptoms of behaviors. An interview was conducted on 5/17/16 at 5:35 PM with the SW. She stated Resident #18 continued to have some behaviors that included yelling out. She indicated sometimes Resident #18 required assistance with something when he was yelling and other times he reported he needed no assistance. She stated he was followed by psychiatric services and had plans of care for behaviors and refusals of care. An interview was conducted on 5/17/16 at 5:45 PM with Nurse #12. She stated she normally worked in the evenings and she was familiar with Resident #18. She indicated Resident #18 continued to have yelling behaviors, but they had decreased some since admission. She stated that if Resident #18 heard someone in the hallway he yelled out repeatedly until staff entered his room. An interview was conducted on 5/18/16 at 10:00 AM with the Director of Nursing (DON). She indicated nursing staff documented behaviors on the behavior monitoring record located on the	F 329		

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F 329	Continued From page 66 MAR or in nursing progress notes. She stated she expected observed behaviors to be documented by nurses. Resident #18's physician's orders for Klonopin were reviewed with the DON. She revealed that behavior monitoring should have been added to the MAR for Resident #18's yelling out behaviors when Klonopin was initially ordered for anxiety on 4/19/16. She indicated she was going to have the behavior monitoring record added to the MAR for Resident #18. The DON additionally stated that if nursing staff felt the yelling out behaviors were for attention rather than anxiety then it wasn't expected to be documented. A physician's order dated 5/18/16 indicated the addition of behavior monitoring to the MAR for Resident #18. The order indicated monitoring for "yelling out, calling to female staff ". The monitoring was to be documented daily on every shift.	F 329		
F 353 SS=G	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this	F 353		6/29/16

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F 353	Continued From page 67 section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to provide a sufficient number of nursing staff to meet the needs of residents as determined by leaving a resident wet, placing a towel between resident's legs instead of using an incontinence brief and leaving a dependent resident in the middle of feeding for an extended period of time for 2 (Resident #35 and #31) of 3 sampled residents reviewed for dignity, failed to provide clean linens for one of three sampled residents observed for pressure ulcer care (Resident #105), failed to provide shower and nail care and failed to provide toileting and feeding assistance for 5 (Residents # 24, #62, #122, #104 & #35) of 6 sampled residents who were dependent or needed extensive assistance with personal hygiene, toileting and eating and failed to perform a comprehensive weekly skin and wound assessments of the pressure ulcers, failed to treat pressure ulcers as ordered and failed to obtain orders for the treatment of ischial, calf and right heel ulcers. The facility also failed to turn and reposition residents and failed to properly adjust the setting of the air mattress for 3 (Residents #35, #24 & #105) of 3 sampled residents with pressure ulcers. The findings included:	F 353	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1) Interventions for affected residents: Resident #35 is discharged. Resident #105 was evaluated and is receiving regular changes in linen and his setting on mattress was adjusted. Resident #31 is receiving appropriate assistance with meals. Resident #24 is discharged.	

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F 353	Continued From page 68 1. Cross reference to tag 241. Based on record review, observation and staff interview, the facility failed to treat residents with respect and dignity by leaving a resident wet, placing a towel between resident ' s legs instead of using an incontinence brief and leaving a dependent resident in the middle of feeding for an extended period of time for 2 (Resident #35 and #31) of 3 sampled residents reviewed for dignity. 2. Cross reference to tag F254. Based on observation and staff interview, the facility failed to provide clean linens for one of three sampled residents observed for pressure ulcer care (Resident #105). 3. Cross reference to tag F312. Based on record review, observation and staff interview, the facility failed to provide shower and nail care and failed to provide toileting and feeding assistance for 5 (Residents # 24, #62, #122, #104 & #35) of 6 sampled residents who were dependent or needed extensive assistance with personal hygiene, toileting and eating. 4. Cross reference to tag 314. Based on record review, observation, resident and staff interview, the facility failed to perform a comprehensive weekly skin and wound assessments of the pressure ulcers, failed to treat pressure ulcers as ordered and failed to obtain orders for the treatment of ischial, calf and right heel ulcers. The facility also failed to turn and reposition residents and failed to properly adjust the setting of the air mattress for 3 (Residents #35, #24 & #105) of 3 sampled residents with pressure ulcers. 5. On 5/15/16 at 3:43PM, an initial tour of the facility was conducted. It was observed that the meal carts were still on the hallway. NA#6 was	F 353	Resident #62, #122, and #104 were evaluated by the Nurse Managers for appropriate assistance with personal hygiene, toileting and eating. 2) Interventions for residents identified as having the potential to be affected: Documentation of showers is provided in PCC by Nurse Aides. Random daily audits by rounding department heads are conducted to assure that residents receive ADL care and showers as scheduled or requested. Facility master schedule has been revised and presented to staff to assure understanding of schedule. A daily staff assignment has been developed to assign staff to specific resident groups. Daily staffing levels will be based on acuity, admissions and discharges the goal is to have no more than (minimal level) 1:15 ratio for day and evening shift Nurse Aides, 1:40 nurse and 1:30 Nurse Aide ratio for night shift. This will be adjusted for acuity daily by nurse management if necessary a nurse can be scheduled on the shift to perform CNA duties. Recruitment and hiring of Nurse Aides will be monitored by the Staff Development Coordinator(SDC). Staff will be hired as available and orientations of new staff will commence within 1 week of offer of employment. Any open positions will be covered by agency personnel in the interim. Staffing patterns will be evaluated	

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F 353	Continued From page 69 observed to obtain a meal tray from the cart for Resident #62 and take it into the resident ' s room. When asked what meal she was giving to Resident #62, she stated it was the lunch tray. NA#6 stated she did not work on that hallway but had come over to assist the nursing assistants working on that hall. On 5/15/16 at 3:43PM, an interview was conducted with NA#7. She stated the lunch trays had arrived on the floor around 2:00PM. When asked why Resident #62 had not received her lunch tray until 3:43PM, she stated she had to get Resident #62 up and dressed before giving her the food tray. On 5/15/16 at 6:50PM, an interview was conducted with Nurse #8. She stated she worked on weekends on the night shift. She stated there were 3 nurses on the hall and usually had 4-5 nursing assistants (NAs). Nurse #8 stated last night (Saturday) there were only 3 NAs for 90 residents. She stated the 11:00PM-7:00AM started out with 2 NAs, then 1 NA came in late. Nurse #8 stated the nursing assistants were " stretched thin " and they got the job done but someone might not get changed as much as they would if they had enough staff. On 5/17/16 at 7:30AM, an interview was conducted with Nurse #10. She stated there was 1 nurse and 1 med aide on days 7:00AM-3:00PM (unless med aide gets pulled, 1 nurse and 1/2 med aide (med aide stayed ½ of the evening shift) on evenings 3:00PM-11:00PM and 1 nurse on her section at night (11:00PM-7:00AM). Nurse #10 stated she had 36 residents on her assignment and it was hard to get everything done. She said she had 2 regular nursing assistants who were responsible for resident care and she relied on them heavily for positioning of	F 353	by the Administrator and Director of Nursing to ensure Nurse Aide assignment is consistent with acuity of residents on assignment with changes made where necessary. Daily, Unit Managers or Weekend Supervisor will validate during rounds and observations timely provision of ADL care. Staffing levels will be maintained to provide services in accordance with resident care plans. On-going staff hiring will be done based on facility needs. 3) Systemic Change Licensed Nurses and Nurse Aides (across all shifts including weekend and as needed(PRN) will be in-serviced by Nursing Management regarding resident ADL care, including timely provision of showers, baths, personal hygiene, incontinence care, assist with meals, ostomy care, and skin care. Education will include resident rights to request or refuse aspects of ADL care and to document any refusals of ADL care so that it is communicated to future caregivers, encouragement of acceptance of ADL care and offering various times. This education will be completed by 06/29/16. Showers will be documented in the resident medical record by the Nurse Aide to allow communication of refusal.	

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F 353 Continued From page 70

residents, that they have splints on, etc. Nurse #10 stated when she did not have 2 nursing assistants on her assignment, she helped the nursing assistant with direct patient care which cut down on her time to do resident assessments, skin assessments, etc. Nurse #10 stated they also had help from other facilities (name of the facilities) and stated they didn ' t get as much help from other facilities now.

On 05/18/2016 at 1:10PM, an interview was conducted with NA#2. He stated he worked 7:00AM-3:00PM and had 10 residents on his assignment today but usually had 15 residents on his assignment. He stated there were times when he did not have enough time to really do his job well. NA#2 stated there were times when he did not have enough time to give showers to residents on their shower days but he would give them a bed bath instead. He did not give specific dates when this occurred.

A review of the actual staff assignment for 7:00AM-3:00PM on 5/17/16 was done. There were 6 assignments on the staffing sheet. Five of the assignments had 15-16 residents per nursing assistant and one assignment had 14 residents per nursing assistant.

On 5/19/16 at 4:13PM, an interview was conducted with the Director of Nursing and the Administrator. The Administrator stated ideally, he would like to have the following staffing ratios: 14 to 15 residents to one nursing assistant for days and evenings and, at the most, 21 residents to one nursing assistant at night.

The Director of Nursing stated her expectation regarding staffing assignments was the following:

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Refusal of showers or care will be immediately reported to Licensed staff or Unit manager by the Nurse Aide so that attempts to encourage or reschedule can be made.

Newly hired staff will be educated by the Staff Development Coordinator regarding completion of ADL's and documentation during orientation period.

Department Managers and Guardian Angels will evaluate for resident concerns during daily Guardian Angel rounds and report during morning meeting. Audits will be completed by interview and/or observation for ADL care and that needs are met, on random residents daily. These audits will be reviewed by Director of Nursing(DON)/or Nurse management and any issues presented to QAPI committee for plan adjustments.

4) Monitoring of the change to sustain system compliance ongoing:

Licensed Nurses and Unit Managers will validate timely completion of ADL's and report to DON any concerns.

Monthly for a minimum of three months, the DON will report concerns of ADL audits to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further

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F 353	Continued From page 71 First shift--10 residents to one nursing assistant, 4 licensed nursing staff, one med aide and 2 unit managers. Second shift-12-13 residents to one nursing assistant, 4 licensed nursing staff and one unit manager. Third shift---23 residents to one nursing assistant and 3 licensed nursing staff.	F 353	auditing beyond the three months.	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse	F 356		6/29/16

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F 356	Continued From page 72 staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post daily staffing information that was accurate for three of five days of the survey. The findings included: On 5/15/16 at 3:15PM, an initial tour of the facility was conducted. The staff posting located in the front lobby of the facility was noted to have the census blank for day and evening shifts. On 5/16/16 at 4:00PM, an observation of the staff posting revealed there were scheduled hours worked and number of staff per shift for the 11:00PM to 7:00AM shift but the census was blank. On 5/17/16 at 12:30PM, an observation of the staff posting was conducted and revealed the number of certified nursing assistants (CNA) listed was eight (8). A review of the actual staff assignment revealed there were seven (7) nursing assistants actually working on the floor with two of the nursing assistants splitting an assignment. On 5/17/16 at 1:00PM, an interview was conducted with NA#9. She stated she was responsible for putting up the staff posting and posts it when she gets in the building around 8:00AM and she puts down who she sees for day and evening shift. NA#9 stated she obtained the census from (name). NA#9 said she worked on the floor today and did not do the staff posting.	F 356	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1) Interventions for affected residents: No residents were identified as being affected. 2) Interventions for residents identified as having the potential to be affected: Human Resources Coordinator(HRC), Staffing Coordinator, Director of Nursing(DON), Unit Manager(UM), Weekend Supervisor, Licensed Nurse or Manager on Duty will post the staffing sheet in the lobby each morning. The nurse supervisor and/or the manager on duty is responsible to post the staffing sheet on weekends/holidays. Staffing sheet will have census, number and hours	

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On 5/17/16 at 1:05PM, an interview was conducted with Director of Nursing who stated she put the staff posting up before the shift started and she must have miscounted. She said she knew the staff posting should have the census number on it.

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of RNs, LPNs and Nurse Aides. A review will be completed by the nurse supervisor or Manager on Duty to compare staffing sheet to actual staff working for accuracy. Any discrepancy will be adjusted and corrected on staffing posted as indicated.

3) Systemic Change:

Staffing posting forms available at Human Resources (HR) office.

The facility Staff Development Coordinator or Regional Clinical Director will provide education to 11p-7a Licensed Nurses, Unit Managers, Supervisors, Staffing Coordinator, Human Resources Coordinator and Manager on Duty related to posting staffing hours. Education will emphasize ensuring completed postings is compared with actual staffing and census for accuracy. This education will be completed by 06/29/16.

An audit will be completed by the Administrator to ensure staffing hours posted accurately reflects actual staffing and census. This audit will be performed weekly for three(3) months.

4) Monitoring of the change to sustain system compliance ongoing:

Staff postings will be checked by Staffing Coordinator, Supervisor, Unit Manager or Manager on Duty daily for corrections.

Monthly for a minimum of three months, the Administrator will report any concerns

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F 356	Continued From page 74	F 356	with staff postings to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the dietary staff failed to wear hair and beard restraints and the facility failed to ensure nourishment refrigerators contained no out of date food/beverages in 1 (station 2) of 2 nourishment refrigerators observed. Findings included: The facility's policy on food handling practices dated 5/21/13 was reviewed. The policy under practice good personal hygiene included to restrain hair appropriately. 1. On 5/18/16 at 11:10 AM, a kitchen observation was conducted. A male dietary staff member #1	F 371	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be	6/29/16

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F 371	Continued From page 75 was observed in the kitchen with no hair or beard restraint. When interviewed, he stated that he would put one on. On 5/18/16 at 11:15 AM, a dietary staff member #2 was observed preparing food for lunch. She was wearing a hair restraint but her hair was not completely covered. When interviewed, she stated that she would fix her hair net to cover all her hair. On 5/18/16 at 11:20 PM, the Dietary Manager (DM) was interviewed. The DM stated that she expected her dietary staff to wear hair/beard restraint while in the kitchen and to cover all hair with a hair restraint. 2. On 5/18/16 at 5:15 PM, the nourishment refrigerators were observed. The nourishment refrigerator on station 2 contained nectar thickened lemon flavored water (237 milliliter (ml) container) dated 4/18/16 (open date) and a honey thickened apple juice (237 ml. container) dated 4/6/16 (open date). The instruction on the container read " after opening use within 5 days. " There was also a container of honey thickened orange juice (237 ml.) dated 4/8/16 (open date). The instruction on the container read " after opening use within 7 days " . On 5/18/16 at 5:20 PM, Nurse #5, nurse on station 2, was interviewed. Nurse #5 indicated that the night shift nurse was responsible for checking the nourishment refrigerator for expired food/beverages. Nurse #5 acknowledged that the 3 thickened beverages were outdated and she was observed to discard the 3 beverages. On 5/19/16 at 4:45 PM, the Dietary manager was interviewed. She stated that it was the responsibility of the dietary aides to check the nourishment refrigerator every day. She indicated that the thickened liquids might have	F 371	completed by the dates indicated. 1) Interventions for affected residents: Based on State, Federal, and local authorities will store, prepare, distribute and serve food under sanitary conditions. On 05/18/16, Staff member # 1 was re-inserviced by the facility Staff Development Coordinator (SDC) or Dietary Manager on the importance of wearing hair net and beard restraint while in the kitchen. On 05/18/16, Staff member # 2 was re-inserviced by the facility SDC or Dietary Manager on the importance of wearing a hair net while preparing food. The nectar thick water was immediately removed from the nourishment refrigerator on Station 2 by the Unit Manager. 2) Interventions for residents identified as having the potential to be affected: On 05/20/16, all other facility nourishment refrigerators were audited by the Unit Manager or Director of Nursing for expired items. No other expired foods were noted. 3) Systemic Change All Dietary staff were in-serviced starting 05/21/16 by the SDC on proper personal hygiene, hair and beard restraint, food storage to include dating and labeling of	

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F 371	Continued From page 76 been at the medication carts when the refrigerator was checked so the dietary aide did not see them.	F 371	foods in all refrigerators. This education will be completed by 06/29/16. Newly hired Dietary staff will be in-serviced during their orientation period by the Dietary Manager regarding proper personal hygiene, hair and beard restraint, food storage to include dating and labeling of foods in all refrigerators. Dietary Manager or Dietary Aide will monitor all nourishment refrigerators daily after dietary aide has replenished and cleaned refrigerator. Monitoring will be done daily both am and pm (including weekends). Dietary Manager will provide individual commercially thickened liquids to eliminate the risk of storing and use of outdated items. Dietary Manager will switch to heavier nets to ensure all staff hair is properly restrained. Dietary Manager or Manager on Duty will audit to ensure hair and beard restraint for dietary staff. This audit will occur three(3) times weekly for three(3) months across all meals including on the weekends. 4) Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three months, the dietary manager will report refrigerator, hair net and beard restraint audits to the Quality Assurance and	

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F 371	Continued From page 77	F 371	Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, resident and staff interview, the facility failed to provide dental services to a resident on Medicaid for one of one sampled resident (Resident #153). The findings included: Resident #153 was admitted to the facility on 6/6/15. Cumulative diagnoses included, in part, cerebrovascular disease, atrial fibrillation, heart failure and hypertension. An Admission Minimum Data Set (MDS) dated 8/13/15 indicated Resident #153 was moderately impaired in cognition. The dental section	F 412	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.	6/29/16

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F 412	Continued From page 78 indicated yes to broken natural teeth. A nursing assessment dated 11/5/15 indicated oral status-- few natural teeth. A Care Area Assessment (CAA) for dental indicated Resident #153 had many broken teeth with cavities and red inflamed gums. She received a mechanical soft diet with no problems noted with chewing of food. Resident #153 denied any pain associated with oral cavity. Proceed to care plan to address dental. A Quarterly MDS dated 2/11/16 indicated Resident #153 was cognitively intact. Dental was noted as no for broken or loosely fitting full or partial denture, mouth or facial pain, discomfort or difficulty chewing. A care plan last reviewed and revised 3/6/16 indicated Resident #153 had potential for oral/ dental health problems as evidenced by a history of poor oral hygiene. Interventions included, in part, to coordinate arrangements for dental care, transportation as needed. On 5/16/16 at 2:21 PM, an interview was conducted with Resident #153. She stated she had only tooth roots on the top and broken teeth on the bottom of her mouth. She stated she had tenderness on the bottom left side of her gums at times. She stated she had not seen a dentist and wanted to have her teeth removed and fixed. On 5/16/16 at 2:3PM, an observation of Resident #153 revealed Resident #153 had broken teeth, tooth roots on the top and multiple missing teeth. A review of the medical record revealed Resident	F 412	1) Interventions for affected residents: Resident #153 was not available for dental appointment during last dental visit. Will be seen by dentist/or dental hygienist at upcoming visit. Next visit scheduled for July 13, 2016. 2) Interventions for residents identified as having the potential to be affected: Licensed Nurses and Unit Managers completed oral assessment on current residents to determine need for dental services. Any resident determined to have dental needs will be seen by the dentist/or dental hygienist on next scheduled visit on July 13, 2016. Social Services will contact residents and family members to advise of appointments and availability of dental services by 06/29/16. 3) Systemic Change On 06/16/16, Social Service Staff were re-educated by the Staff Development Coordinator or Regional Clinical Director on ensuring facility routinely provides dental services and scheduling of emergency dental services as indicted. Nurse Aides and Licensed Nurses (across all shifts including weekend and as needed(PRN) scheduled) will be educated by the Staff Development Coordinator or Regional Clinical Director regarding dental	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

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#153 had not been seen by a dentist since her admission to the facility.

On 5/19/2016 at 11:03 AM, nurse #3 stated Resident #153 had not complained to her about her teeth hurting. She stated there was a dentist that came to the facility and the residents go to see him.

On 5/19/16 at 4:02 PM, an interview was conducted with the Administrator who stated Resident #153 had not been seen by the dentist and had not been on the dental list to be seen. He stated the social worker had recently taken over the responsibility for the dental list. The Administrator stated his expectation was that residents be seen by the dentist every six months.

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services and how to refer a resident for dental services. This education will be completed by 06/29/16.

Newly hired Licensed Nurses and Nurse Aides will be educated during their orientation period by the Staff Development Coordinator regarding dental services and how to refer a resident dental service services.

Licensed Nurses will document any oral assessment issues in the resident medical record. Further, Social services will be notified of the resident need for appointment.

Dental status to be assessed and documented in the resident medical record by the Licensed Nurse upon admission. Admission assessments will be reviewed for oral evaluation completion by the nurse management team at morning clinical meeting within 72 hours of admission.

4) Monitoring of the change to sustain system compliance ongoing:

Results of oral assessments to be reviewed and communicated to Social Services.

Monthly for a minimum of three months, the Director of Nursing will report any dental services concerns to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance

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F 412	Continued From page 80	F 412	Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and staff and pharmacist interview, the facility's pharmacist failed to address the continued use of an antibiotic and failed to address the need to monitor the Thyroid Stimulating Hormone (TSH) level for a resident on a thyroid hormone drug for 2 (Residents #126 & #8) of 5 sampled residents reviewed for unnecessary medications. Findings included: 1. Resident # 126 was admitted to the facility on 4/13/14 with multiple diagnoses including Congestive Heart Failure (CHF). The annual Minimum Data Set assessment dated 3/30/16 indicated that Resident #126 ' s cognition was intact and she had received antibiotic medication during the last 7 days.	F 428	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1) Interventions for affected residents:	6/29/16

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F 428	Continued From page 81 The May, 2016 physician's orders for Resident #126 was reviewed. The orders included Nitrofurantoin (an antibiotic drug) 50 milligrams (mgs.) by mouth daily indefinitely for prophylaxis. The order indicated that Nitrofurantoin was started on 3/26/15. On 5/19/16 at 1:14 PM, the Director of Nursing (DON) was interviewed. The DON indicated that the indication for the use of Nitrofurantoin was for prophylaxis. She further stated that the resident had Urinary Tract Infection (UTI) in the past. Review of the laboratory results revealed that Resident #126 had urinalysis and urine culture and sensitivity done 4/19/15. On 5/19/16 at 2:45 PM, the pharmacist was interviewed. The pharmacist indicated that Resident #126 had been treated for UTI years ago and was kept on Nitrofurantoin to prevent further UTI. The pharmacist confirmed that he did not address the continued use of the antibiotic with the physician or Director of Nursing. 2. Resident #8 was admitted to the facility on 11/25/11. With multiple diagnoses including hypothyroidism. The Quarterly Minimum Data Set indicated Resident #8 was severely impaired on cognition. The May 2016 physician's orders for Resident #8 was reviewed. The orders included Levothyroxine (thyroid medication) 25 micrograms by mouth daily. There was not an order to monitor the TSH level. A review of the medical record revealed the last TSH level was completed on 8/14/14. On 5/19/16 at 2:45PM, the pharmacist was interviewed. The pharmacist stated he had	F 428	Resident #126 antibiotic was discontinued on 5/24/16. Resident #8 had lab work completed on 5/27/16. Results were within normal limits. 2) Interventions for residents identified as having the potential to be affected: Pharmacy consultant completed an in-house audit on 5/31/16. Pharmacy recommendations were initiated for any irregularities. Recommendations will be submitted to the physician by the Director of Nursing and acted upon by 06/29/16. On 06/24/16, a facility antibiotic review will be completed by the Unit Manager. Any identified issues will be communicated to the Physician and addressed on 06/24/16. 3) Systemic Change On 06/01/16, a new Pharmacy Consultant was added for additional review of drug regimen. Licensed Nurses (across all shifts including weekend and as needed(PRN) scheduled) will be educated by the facility Staff Development Coordinator or Regional Clinical Director on appropriate lab monitoring and antibiotic orders. Antibiotics will be ordered with stop dates. Scheduled monthly lab order binder will be placed at nurse station for future labs. This education will be completed by 06/29/16.	

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F 428	Continued From page 82 reviewed Resident #8's medications on his computer and did not see that Levothyroxine was an active medication. The pharmacist stated the TSH level was usually checked yearly and after medication dose changes. He stated he had not made any recommendations to monitor the TSH level and he possibly could have missed it.	F 428	Newly hired Licensed Nurses will be educated during their orientation period by the Staff Development Coordinator regarding appropriate lab monitoring and antibiotic stop dates. 4) Monitoring of the change to sustain system compliance ongoing: Monthly pharmacy audits will be reviewed by Director of Nursing (DON) and Unit Managers. Monthly for a minimum of three months, the DON will report any lab audit concerns to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	
F 490 SS=D	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 record review, staff interviews, resident interview and observations, the facility failed to	F 490	The statements included are not an admission and do not constitute	6/29/16

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F 490	Continued From page 83 have an adequate supply of incontinence briefs and gloves for one of one sampled resident (#35). The findings included: This tag is cross referenced to: 1. F 241. Dignity: Based on record review, observation and staff interview, the facility failed to treat residents with respect and dignity by leaving a resident wet, placing a towel between a resident ' s legs instead of using an incontinence brief and leaving a dependent resident in the middle of feeding for extended period of time for 2 (Residents # 35 & #31) of 3 sampled residents reviewed for dignity. An interview was conducted with Resident #35 on 5/16/16 at 4:23 PM. The resident stated the facility has run out of incontinence briefs and gloves. An interview was conducted with NA #1 on 5/18/16 at 12:15 PM. She stated the facility has run out of certain sizes of incontinence briefs and a different size has been used on the residents when needed. NA #1 stated incontinence briefs have been obtained from other facilities when needed. An interview was conducted with Central Supply Staff #1 on 5/19/16 at 9:20 AM. She stated she had worked in central supply department for the past three weeks and was responsible for ordering nursing supplies. She stated when she accepted the position, there were no full-time staff members responsible for ordering supplies. She stated when she first began ordering supplies, the facility was out of size medium and large gloves and was completely out of incontinence briefs.	F 490	agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1) Interventions for affected residents: Resident #35 is discharged. 2) Interventions for residents identified as having the potential to be affected: PAR levels will be maintained in central supply and station supply closets by central supply clerk to ensure adequate supplies. Established order system for routine supplies. In case of emergencies, will be immediately obtained by the Central Supply Clerk, Director of Nursing or Administrator from Raleigh Rehab, a sister facility. New admissions (including weekend admissions) with supply needs will be immediately communicated by the Director of Nursing, Unit Manager or Nurse Supervisor to Central Supply Clerk for ordering.	

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F 490	Continued From page 84 The nursing assistants have informed her they were out of a certain size of incontinence brief and back up supplies have been obtained from another facility when needed.	F 490	3) Systemic Change On 06/17/16, the Central Supply Clerk was inserviced by the facility Director of Nursing and Regional Clinical Director on the central supply process with emphasis on maintaining PAR levels to avoid supply stock issues. Central supply area reorganized. Nurses stations supply closets reorganized. Licensed Nurses to notify central supply of specific needs to include extensive use of specific supplies. Clipboards with supply request sheets will be available at each nursing station to be completed and submitted to Central Supply Clerk when a supply is in need. An audit will be completed by the Medical Records Nurse, Unit Manager or Director of Nursing (DON) of PAR levels for supplies to ensure supply items are at established PAR and supplies are adequate. The audit will be performed weekly for three(3) months. 4) Monitoring of the change to sustain system compliance ongoing: Central supply will notify Director of Nursing of need for additional supply orders or obtaining supplies from sister facility. Monthly for a minimum of three months,	

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F 490	Continued From page 85	F 490	the central supply clerk will report any supply needs/concerns to DON, DON will report and address during the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	
F 505 SS=D	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff and physician interview, the facility failed to notify the physician of a critical INR (international normalized ratio-a lab used to monitor individuals being treated with the blood thinning medication Coumadin) for one of five sampled residents reviewed for unnecessary medication (Resident #122). The findings included: Resident #122 was admitted to the facility 11/19/14 and readmitted to the facility on 4/9/16. Cumulative diagnoses included, in part, history of deep vein thrombosis (blood clots) and acute embolism and thrombosis of deep veins in the lower extremity. A physician order dated 4/9/16 stated Coumadin 3 milligrams (mg) by mouth every night	F 505	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1) Interventions for affected residents: Resident #8 labs were drawn on 6/13/16	6/29/16

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A physician order dated 4/15/16 indicated obtain PT (prothrombin time)/ INR every Monday and Thursday.

A review of the medical record revealed only one laboratory test result for PT/ INR dated 5/11/16.

On 5/18/16 at 3:00PM, the Director of Nursing provided the PT/INR laboratory results for April and May 2016. She stated she had printed off the laboratory results today and thought the original laboratory reports were in the physician ' s book. The Director of Nursing was unable to provide the original PT/INR laboratory results for April 2016.

A review of the April 2016 PT/ INR laboratory results revealed that the PT/INR laboratory level on 4/25/16 was 34.3 with INR at 4.07. Normal values are PT-11.6-15.2 and INR less than 1.5 with therapeutic range of INR generally 2.0-3.0.

A review of the medical record revealed no documentation that the physician had been notified of the laboratory results on 4/25/16.

On 5/19/16 at 2:00PM, an interview was conducted with Resident #122's physician. She stated she could not remember if staff called her with the PT/ INR and, if she had known the laboratory results, she would have ordered the Coumadin to be held and get a repeat PT/INR.

On 5/19/16 at 4:13PM, an interview with the Director of Nursing was conducted. She stated she expected nursing staff to call the physician for a critical lab value such as the PT/INR result on 4/25/16 for Resident #122, fax the results of

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and the results were reported to the physician on 6/13/16.

Resident #122 lab results were reported to physician on 6/16/16.

2) Interventions for residents identified as having the potential to be affected:

On 6/9/16, Licensed Nurses and Unit Managers audited current lab orders for current facility residents. Facility audit conducted for lab reporting and notification to physician.

3) Systemic Change

Licensed nurses (across all shifts including weekend and as needed (PRN) scheduled) will in-serviced by the Staff Development Coordinator or Regional Clinical Director on transcribing resident lab orders in Point Clink Care (electronic medical record) and lab book in a timely manner and ensure labs are completed as ordered. Also, education will include notifying physician of lab results and placing date and time on lab while on paper with notification documented in resident medical record by the Licensed Nurse. This education will be completed by 06/29/16.

Newly hired licensed staff will be inserviced during orientation period by the facility Staff Development Coordinator on transcribing resident lab orders in Point Clink Care (electronic medical record) and lab book in a timely manner and ensure

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F 505	Continued From page 87 the laboratory test to the physician and write a nursing note.	F 505	labs are completed as ordered. Also, education will include notifying physician of lab results and placing date and time on lab while on paper with notification documented in resident medical record by the Licensed Nurse. Unit managers will audit new admission orders to make sure lab orders are transcribed appropriately. Binders will be developed for future lab draws and will be kept at the nurses station. Labs will be received electronically when system becomes available. Weekly for (3) months, lab audits will be completed by the Director of Nursing or Unit Manager on all residents with current lab orders to ensure labs are drawn as ordered and notification of results to physician is noted in the resident medical record. 4) Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three months, the DON will report any lab audit concerns to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	

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F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to maintain complete and accurate medical records for three of five sampled residents reviewed for unnecessary medications (Resident #122, #126 and #18). The findings included: 1. Resident #122 was admitted to the facility 11/19/14 and readmitted to the facility on 4/9/16. Cumulative diagnoses included, in part, history of deep vein thrombosis (blood clots) and acute embolism and thrombosis of deep veins in the lower extremity. A physician order dated 4/9/16 stated Coumadin 3 milligrams (mg) by mouth every night A physician order dated 4/15/16 indicated obtain PT (prothrombin time)/ INR every Monday and Thursday.	F 514	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1) Interventions for affected residents: On 6/16/16, Resident #122 had lab drawn as ordered. Results of the labs were reviewed by the physician on 06/16/16.	6/29/16

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A review of the medical record revealed only one laboratory test result for PT/ INR dated 5/11/16.

On 5/18/16 at 3:00PM, the Director of Nursing provided the PT/INR laboratory results for April and May 2016. She stated she had printed off the laboratory results today and thought the original laboratory reports were in the physician's book. The Director of Nursing was unable to provide the original PT/INR laboratory results for April 2016.

A review of the laboratory results provided by the Director of Nursing for PT/INR revealed that the PT/INR was drawn in April 2016 on the following dates: 4/11/16, 4/18/16, 4/21/16, 4/25/16 and 4/29/16.

On 05/19/2016 at 5:56 PM, an interview was conducted with the Administrator and the divisional clinical director. They stated they felt the omission of laboratory results in the medical record was due to the transition to an electronic record and transition of staff as the facility had not had a medical records person since sometime in March and had just filled the position.

2. Resident # 126 was admitted to the facility on 4/13/14 with multiple diagnoses including Congestive Heart Failure (CHF). The annual Minimum Data Set assessment dated 3/30/16 indicated that Resident #126 ' s cognition was intact.
The May, 2016 physician's orders for Resident #126 was reviewed. The orders included Metoprolol (drug used to treat Hypertension) 50 milligrams (mgs) - give 1 and 1/2 tablet by mouth twice a day for Hypertension. The order indicated

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Resident #126 order was reviewed by the physician on 06/16/16.

Resident #18's lab results were reviewed by the physician on 06/16/16.

Lab results were filed by medical records on 06/16/16. These results are also in the resident electronic medical record.

2) Interventions for residents identified as having the potential to be affected:

On 06/14/16, the facility Medical Records Clerk was assisted by an additional Medical Records Clerk from a sister facility to reorganize and file medical records.

Labs will be filed daily by the Medical Records Clerk.

3) Systemic Change

Licensed Nurses (across all shifts including weekend and as needed (PRN) scheduled) will be re-educated by the Staff Development Coordinator or Regional Clinical Director regarding reporting of labs and reviewing with Physician, documentation in the resident medical record of notification and physician follow up. This education will be completed by 06/29/16.

Newly hired Licensed Nurses will be educated during their orientation period by the Staff Development Coordinator

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that Metoprolol was started on 3/26/15.
The electronic Medication Administration Records (MARs) for March, April and May, 2016 were reviewed. The records indicated that Resident #126 had received 1 tablet of Metoprolol twice a day instead of 1 and ½ tablets as ordered.
On 5/19/16 at 12:14 PM, Nurse #9 was interviewed. She stated that nurses were administering 1 and ½ tablets of Metoprolol but the MARs were showing only 1 tablet.
On 5/16/16 at 12:15 PM, the medication cart was observed. There was a packet of 50 mgs - 1 tablet and a packet of 50 mgs - ½ tablet observed in the cart for Resident #126.
On 5/19/16 at 4:25 PM, interview with the DON revealed that the pharmacy would fix the inaccurate MAR for Resident #126. She indicated that the pharmacy would revise the MAR to reflect two separate orders (50 mgs and 25 mgs) for the Metoprolol.
3. Resident #18 was admitted to the facility on 3/29/16 with multiple diagnoses including epilepsy, encephalopathy, history of Phenobarbital toxicity, and hyperlipidemia.

A physician's order dated 3/30/16 indicated an order for laboratory tests: lipid panel, Phenobarbital level, CBC (complete blood count) with differential and platelets, and BMP (basic metabolic panel) for Resident #18.

A physician's order dated 4/13/16 indicated an order for laboratory tests: CBC with differential and platelets and BMP for Resident #18.

A physician's order dated 4/26/16 indicated an order for laboratory tests: CBC, CMP (comprehensive metabolic panel), valproic acid level, and Phenobarbital level for Resident #18.

F 514

regarding reporting of labs and reviewing with Physician, documentation in the resident medical record of notification and physician follow up.

On 06/16/16, the Medical Records Clerk was in-serviced by the Staff Development Coordinator regarding appropriate and timely filing of resident records.

Weekly for three(3) months, the Unit Manager or Director of Nursing will audit the medical record of residents with recent lab orders to ensure lab results are filed in the resident medical record.

Unit managers or Weekend Supervisor will follow up on pending labs daily during clinical meeting.

4) Monitoring of the change to sustain system compliance ongoing:

Admission and discharge records will be evaluated by Medical Records Clerk. Any concerns will be addressed and corrected.

Monthly for a minimum of three months, the DON will report any concerns related to medical records identified by medical records clerk to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345077	A. BUILDING ______ B. WING ______	C 05/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 514	Continued From page 91 A review of Resident #18's medical record revealed laboratory results for the 3/30/16 lipid panel, CBC with differential and platelets, and BMP. The laboratory results indicated the results of the Phenobarbital level was pending. There were no additional laboratory result in Resident #18's medical record. An interview was conducted on 5/17/16 at 4:20 PM with Nurse #11. She indicated she was not sure if the laboratory tests were completed for Resident #18. She stated she was going to follow up with the laboratory to verify if the orders for the laboratory tests were completed. A follow up interview was conducted on 5/17/16 at 4:55 PM with Nurse #11. She indicated that all of the laboratory tests for Resident #18 had been completed as ordered and viewed by the physician. She stated she was unable to find the original laboratory results, but she had gotten new copies of the laboratory result. The laboratory results included the Phenobarbital level from 3/30/16, as well as results from each laboratory test ordered on 4/13/16 and 4/26/16 for Resident #18. The laboratory results were each signed by the Physician's Assistant and dated 5/17/16. An interview was conducted on 5/17/16 at 5:00 PM with the Physician's Assistant. She indicated she had viewed all of the laboratory results for Resident #18 previously. She stated she signed them with the current date (5/17/16) because staff were unable to locate the originals that had previously been signed and dated. She indicated the facility was without a medical records staff person for a couple of months and there had been a back log of items that were not filed.	F 514		

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F 514	Continued From page 92 An interview was conducted on 5/19/16 at 5:56 PM with the Administrator and the Divisional Clinical Director. They stated they felt the omission of laboratory results in the medical record was due to the transition to an electronic record and transition of staff as the facility had not had a medical records person since sometime in March and had just filled the position.	F 514		
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. 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.	F 520		6/29/16

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F 520	Continued From page 93 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility ' s Quality Assessment and Assurance committee (QAA) failed to implement, monitor and revise as needed the action plan developed for the recertification survey dated 7/31/15 in order to achieve and sustain compliance. The facility had a pattern of repeat deficiencies for notification of changes (F157), assessment accuracy (F278), kitchen (F371), dental services (F412) and complete and accurate records (F514) on the recertification survey 7/31/15 and the recertification survey on 5/19/16. The findings included: The tag is cross referenced to F157. Based on medical record review, physician and staff interview, the facility failed to notify the physician of a resident experiencing low blood pressures and of staff not administering blood pressure medications as ordered for one of five sampled residents reviewed for unnecessary medications (Resident #122). On 5/19/16 at 5:56 PM, an interview was conducted with the Administrator and the Divisional Clinical Director. They stated a lot of information was exchanged in the morning meeting and there were a lot of opportunities to share medical information that would possibly resolve the problem. Creating a morning meeting format would allow them to validate that the physician was being informed as needed and laboratory work was being completed. The tag is cross referenced to F 278. Based on medical record review and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessments accurately for active diagnosis for 2 of 5 sampled residents (Resident #39 and #122).	F 520	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1.Interventions for affected resident: All survey related issues and concerns were discussed and reviewed during morning meeting with preliminary audits beginning immediately following survey exit. All concerns related to residents still in-house were addressed. 2.Interventions for residents identified as having the potential to be affected: Morning meeting format will be utilized to review resident charts and evaluate potential opportunities for corrections, discuss and review resident needs for services, and identify record concerns. Quality Assurance and Performance Improvement (QAPI) Committee will continue to meet monthly to address concerns and audits	

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F 520	Continued From page 94 On 5/19/16 at 5:56 PM, the Divisional Clinical Director stated switching over to a computerized system had been a challenge for everyone and that might have impacted the repeat tag. The tag is cross referenced to F371. Based on record review, observation and staff interview, the dietary staff failed to wear hair and beard restraints and the facility failed to ensure nourishment refrigerators contained no out of date food/beverages in 1 (station 2) of 2 nourishment refrigerators observed. On 5/19/16 at 5:56 PM, the Administrator and the Divisional Clinical Director stated they needed to do daily audits where people check things such as the nourishment refrigerator and also this would be included in the guardian angel program where administrative staff were assigned a certain area and certain residents for customer satisfaction. The tag is cross referenced to F412. Based on observation, medical record review, resident and staff interview, the facility failed to provide dental services to a resident on Medicaid for one of one residents (Resident #153). On 5/19/16 at 5:56 PM, the Administrator and the Divisional Clinical Director stated the facility had already fixed who would do the scheduling for the podiatrist, optometrist and dentist. They stated they would go back and oral assessments would be done on all residents to determine if dental services were needed for long term care residents. The tag is cross referenced to 514. Based on medical record review and staff interview, the facility failed to maintain complete and accurate medical records for three of five residents reviewed for unnecessary medications (Resident #122, #126 and #18). On 5/19/16 at 5:56 PM, the Administrator and the	F 520	and determine further recommendations. 3.Systematic Change: On 05/23/16, the facility implemented the use of Electronic I-pads for the Nurse Aides to assist and ensure complete activities of daily living(ADL) documentation and to allow streamlined ADL documentation directly into the resident medical record. The Regional Clinical Director educated the facility QAPI Committee members on 06/16/16 regarding development of plan of corrections and monitoring for ongoing system compliance. Discussion of facility QAPI Committee was completed during morning meeting on 06/16/16. Topics included ensuring the QAPI Committee oversees and identifies all efforts that improve the quality of care in the facility by monitoring performance measures, directing improvement actions by correcting and sustaining compliance and evaluating the effectiveness of quality management activities. Additional issues or concerns will be reviewed by QAPI Committee members during morning meeting and evaluated for changes in plan. 4.Monitoring of the change to sustain system compliance ongoing: Monthly and during ad hoc QAPI meetings for a minimum of twelve (12) months, department managers will report audit	

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F 520	Continued From page 95 Divisional Clinical Director stated they felt this was due to the transition to electronic records and transition of staff as they had not had a medical records person since sometime in March and had just filled the position.	F 520	results to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	