

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345221</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/10/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRIAN CENTER H &amp; REHAB WEAVERV</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>78 WEAVER BOULEVARD</b> <b>WEAVERVILLE, NC 28787</b>	
(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 224 SS=D	<p>483.12(a)(1) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN</p> <p>a) The facility must-</p> <p>(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on medical record review, observations and staff interviews the facility failed to serve all food to 1 of 1 sampled residents served food in separate bowls/one at a time when observations were made at 3 separate meals (Resident #119). In addition, the facility failed to provide incontinence care to a resident that was known to be soiled prior to being served food at 1 of 3 meals observed (Resident # 114).</p> <p>The findings include:</p> <p>1. Resident #119 was admitted to the facility 02/20/14 with diagnoses which included metabolic encephalopathy, dementia without behavioral disturbance, severe protein calorie malnutrition, diabetes, chronic kidney disease, anemia, dehydration, and vitamin D deficiency. The physician's diet order for Resident #119 was puree diet with large portions, fortified oatmeal at breakfast.</p> <p>The current Minimum Data Set (MDS) for Resident #119 dated 01/20/17 noted severe cognitive impairment, supervision with eating with 1 person assistance, a height of 66 inches, a weight of 98 pounds and on a mechanically altered diet.</p> <p>The current care plan updated 01/28/17 for Resident #119 included the following problem</p>	F 224	<p>Criteria 1</p> <ul style="list-style-type: none"> <li>On 2/11/17 the Nurse Manager ensured that all bowls of food were offered to Resident #119 and additional servings were requested from Dietary as required.</li> <li>On 2/9/17 the Nurse Aide and Charge Nurse provided incontinent care for Resident #114 following completion of the breakfast meal.</li> </ul> <p>Criteria 2</p> <ul style="list-style-type: none"> <li>Current residents requiring assistance with meals and incontinent care have the potential to be affected by this alleged deficient practice.</li> <li>By 3/10/17 an audit was completed by the Nurse Managers to identify current residents who require assistance with meals and incontinence care and observe completion.</li> </ul> <p>Criteria 3</p> <ul style="list-style-type: none"> <li>Nursing Staff have been re-educated by the Administrator, DON &amp; Nurse Managers regarding the expectation of providing residents with assistance of</li> </ul>	3/10/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

03/03/2017

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

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F 224	<p>Continued From page 1</p> <p>areas:</p> <p>-Resident #119 has activity of daily living self-care performance deficit. She has dementia with impaired needs awareness, ability to follow instructions. Able to self feed with supervision, set-up. Approaches to this problem area included set up meals, food in separate bowls, eats in main dining room.</p> <p>-Resident #119 has a communication problem. She has dementia with impaired ability to understand and make self understood. She is nonverbal except for occasionally mumbling. Rarely/never understood and rarely/never understands: staff to anticipate and meet needs.</p> <p>-Resident #119 has weight of 97.1 pounds. Weight below ideal but did not have significant weight loss. Continues to feed self, intake 75-100%. Occasional total assist with feeding, continue diet per order, encourage oral fluids every hour. Approaches to this problem area included may serve one bowl at a time to decrease overstimulation and increase meal intake; meal assistance, supervision/meal set-up, take to main dining room for meals, food in separate bowls, maroon spoon; observe intake and record every meal and recommend food in bowls and maroon spoon to aide in self feeding.</p> <p>Review of the weight record for Resident #119 over the past six months noted the lowest weight recorded at 90 pounds (09/04/16) and the highest weight recorded at 98 pounds (01/10/17).</p> <p>Resident #119 had been seen by the speech therapist from 06/21/16-07/20/16. At discharge from speech therapy recommendations were made to, "Set-up patient with individual bowl, one at a time to reduce visual distractions; provide occasional supervision to promote initiation and</p>	F 224	<p>completion of ADLs with a focus surrounding preparing residents for mealtime and providing assistance with meals including tray set up and assistance with feeding and specifically offering all bowls served on the meal tray to Resident #119 at each meal by 3/10/17. Nursing Staff have been re-educated by the Director of Nursing and Nurse Managers regarding providing incontinent care prior to meals by 3/10/17</p> <ul style="list-style-type: none"> <li>A meal service audit will be completed and documented by a Nurse Manager 3 times per week for 12 weeks on varying shifts and days of the week to validate incontinent care needs are met prior to initiating meal service, adequate supervision is observed to promote dignity during meals, and offering assistance with tray set up and feeding assistance during meals.</li> </ul> <p>Criteria 4</p> <ul style="list-style-type: none"> <li>To assure continued compliance with these processes, the Unit Manager will present the audit summary results at the QAPI meeting each month. The process will continue for ninety days or as directed by the QAPI Committee.</li> </ul>		

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F 224	<p>Continued From page 2 attention to task through completion."</p> <p>On 02/10/17 at 10:00 AM the occupational therapist stated the maroon spoon had been used for Resident #119 for quite some time. The occupational therapist explained the maroon spoon was used for Resident #119 for safety because it limited the amount of food that could be ingested at one time. The occupational therapist stated Resident #119 was able to feed herself but needed the maroon spoon and to be served one bowl at a time due to her impulsivity and distractibility.</p> <p>Resident #119 was observed eating at 3 separate meals and these observations included the following:</p> <p>-02/06/17-Resident #119 was observed seated in a reclined geri chair, at a table, in the main dining room for the lunch meal service. At approximately 12:52 PM the tray for Resident #119 was removed from the delivery cart and placed on a counter, out of reach of Resident #119. A maroon spoon and bowl of food from this tray was placed in front of Resident #119 and she immediately began to eat. When completed, two other bowls of food and a milkshake (one at a time) were provided to Resident #119 which she readily consumed. At 1:15 PM Nurse Aide #3 placed the last bowl of food consumed by Resident #119 on the tray and removed the tray for Resident #119 from the counter and placed it on the delivery cart (which now contained trays from meals consumed by other residents). The tray for Resident #119 was examined and 2 additional bowls of food on the tray had not been uncapped or offered to Resident #119. Review of the tray card for Resident #119 noted puree</p>	F 224			

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F 224	<p>Continued From page 3</p> <p>chicken, puree green peas and puree bread had been served and consumed by Resident #119 and puree rice pilaf and puree fruit had not been uncapped or offered as part of the lunch meal. When questioned, Nurse Aide #3 stated that Resident #119 usually didn't eat all her food and stated it was a mistake to not offer the rice and fruit as part of the lunch meal. At 1:19 PM Nurse Aide #3 went to the kitchen to request a fresh bowl of puree rice and provided it to Resident #119. Resident #119 heartily ate the puree rice and licked the bowl when the contents were gone. At approximately 1:25 PM the bowl containing the puree rice was removed from Resident #119, the clothing protector was taken off Resident #119 and used to wipe her mouth. Another staff member came over to remove Resident #119 from the dining room and take her back to her room. At that time Nurse Aide #3 was asked about the bowl of fruit that had not been served to Resident #119 as part of the lunch meal. At approximately 1:30 PM another clothing protector was placed on Resident #119, a bowl of applesauce was given to her and Resident #119 ate all the applesauce. Nurse Aide #3 had no explanation why the fruit had not been served to Resident #119.</p> <p>-02/07/16-Resident #119 was observed seated in her geri chair, in her room for the supper meal. The tray for Resident #119 was delivered to the room at approximately 6:19 PM and left at the counter, out of reach of Resident #119. A maroon spoon and bowl of food from this tray was placed in front of Resident #119 and she immediately began to eat. When completed, other bowls of food (one at a time) were provided to Resident #119 which she readily consumed. At approximately 6:50 PM the tray for Resident #119</p>	F 224			

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F 224	<p>Continued From page 4</p> <p>was removed from the room and placed on the delivery cart (which now contained trays from meals consumed by other residents). The tray for Resident #119 was examined and 1 additional bowl of food on the tray had not been uncapped or offered to Resident #119. Review of the tray card for Resident #119 noted puree grilled cheese sandwich, puree broccoli and puree cream of tomato soup had been offered and eaten. An uncapped bowl of puree peaches remained on the tray for Resident #119. When questioned, Nurse Aide #4 stated she missed offering the bowl of fruit to Resident #119.</p> <p>-02/08/17-Resident #119 was observed seated in her geri chair, in the main dining room for the breakfast meal. At approximately 8:43 AM the tray for Resident #119 was placed out of reach of Resident #119 on the table where Resident #119 was seated. A maroon spoon and bowl of food from this tray was placed in front of Resident #119 and she immediately began to eat. At 9:08 AM the tray for Resident #119 was removed from the table and placed on the delivery cart (which now contained trays from meals consumed by other residents). The tray for Resident #119 was examined and 1 bowl of food had not been uncapped or offered to Resident #119. Review of the tray card for Resident #119 noted puree eggs, puree sausage and puree bread had been offered and consumed but the puree super cereal (fortified oatmeal) had not been offered. When questioned, Nurse Aide # 5 stated she missed offering the puree super cereal (fortified oatmeal) to Resident #119. At approximately 9:14 AM Nurse Aide # 5 requested another bowl of puree super cereal for Resident #119. Resident #119 ate all the super cereal and scraped the sides of the bowl when completed.</p>	F 224			

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F 224	<p>Continued From page 5</p> <p>Review of meal intake records for Resident #119 from 01/01/17-2/10/17 noted out of 85 meals: 76-100% intake 58 meals 51-75% intake 14 meals 26-50% intake 5 meals 0-25% intake 7 meals 1 refusal of a meal</p> <p>On 02/10/17 at 3:27 PM the administrator and director of nursing stated they expected all food to be served to residents at meals, including Resident #119.</p> <p>2. Resident #114 was admitted to the facility on 03/03/16. His diagnoses included dementia, restlessness and agitation, muscle weakness, and chronic pain syndrome.</p> <p>The annual Minimum Data Set dated 01/19/17 coded him with severely impaired cognition, verbal behaviors 1 to 3 times in previous 7 days, rejection of care 4 to 6 times in the previous 7 days, and having worse behaviors since the previous assessment. It was coded that he required extensive assistance with transfers, toileting and hygiene. He was also coded as being always incontinent of bowel and bladder.</p> <p>Review of the care plan related to actual urinary incontinence reviewed/revised on 01/28/17 had the goal that his dignity would be maintained with staff assistance for toileting needs and will remain</p>	F 224			

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F 224	<p>Continued From page 6</p> <p>clean and dry with staff intervention. The interventions included to assist to toilet every 2 hours and check and change on routine rounds every 2 to 3 hours as needed and to provide assistance as required for toileting, requiring extensive assistance of 1 to 2 staff.</p> <p>Another care plan for bladder incontinence related to dementia last revised on 01/28/17 included the goal to have decreased frequency of urinary incontinence and prevent infections. The interventions included to check every 2 hours and as required for incontinence. Wash rinse and dry perineum. change clothing as needed after incontinence episodes and toilet every 2 hours while awake.</p> <p>On 02/09/17 at 9:16 AM, family reported that Resident #114 was wet this morning and all staff did was change his gown and give him a clean blanket for his lap but that no one changed him for breakfast. He was sitting in a gerichair across from the nursing station at this time.</p> <p>On 02/09/17 at 9:34 AM, Nurse Aides (NA) #1 and #2 assisted Resident #114 to the shower room and proceeded to assist him to the commode. Resident #114 stood and was noted to have the blanket upon which he was sitting soaked with urine and his pants and brief were soaked with urine. When the NAs were asked about the last time he was checked and toileted, they responded that they had not checked or toileted him since coming on at 7:00 AM.</p> <p>On 02/09/17 at 10:11 AM Nurse #1 stated during interview that as staff were passing the breakfast trays, she noticed that Resident #114's gown was wet. She stated that she could not provide the</p>	F 224			

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F 224	Continued From page 7 care herself so she wanted to make him as comfortable as possible and change his gown and blanket and then he received his breakfast tray.  A follow up interview with NA #1 on 02/10/17 at 1:38 PM revealed that when staff arrived at 7 AM on 02/09/17, they offered to get him dressed. He stated no. Staff further stated he was more cooperative with family around.  Upon follow up interview on 02/10/17 at 1:30 PM, Nurse #1 stated Resident #114's gown had been wet about 6 inches in diameter around the left front of his stomach. She stated she assumed it was urine. She stated he required 2 persons to transfer and staff were passing trays so she decided to try and make him as comfortable as she could. Resident #114 was known to urinate excessively due to his diuretic use and refused care at times.  Interview with the Director of Nursing on 02/10/17 at 3:00 PM revealed she expected staff to check residents for incontinence prior to meal services. She further stated that if a resident was visibly wet at the meal, she would want that resident changed and not sitting and eating soiled.	F 224			
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  483.12 (b) The facility must develop and implement written policies and procedures that:  (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of	F 226		3/10/17	

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F 226	<p>Continued From page 8 resident property,</p> <p>(2) Establish policies and procedures to investigate any such allegations, and</p> <p>(3) Include training as required at paragraph §483.95,</p> <p>483.95</p> <p>(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-</p> <p>(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.</p> <p>(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property</p> <p>(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to ensure a Nurse Aide had renewed her Nurse Aide certification but continued to work after her certification had expired for review of 1 of 5 personnel files for abuse prohibition (NA #6).</p> <p>Findings included:</p> <p>A review of a Human Resource policy titled Employee Credentials with a revised date of July 2016 which was referenced as a related standard in the facilities Abuse and Neglect Prohibition</p>	F 226	<p>Criteria 1</p> <ul style="list-style-type: none"> <li>Nurse Aide #6 was immediately removed from the Nursing Schedule on 2/10/17 by the Director of Nursing and the Scheduler was notified that she could not be asked to work again until this was cleared by the Director of Nursing. The renewed certification for Nurse Aide #6 was received on 2/23/17 with certification dates reflecting 5/15/2002 -01/31/2019. The Scheduler was notified by the Director of Nursing on (need date) that the</li> </ul>		

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F 226	<p>Continued From page 9</p> <p>Policy indicated a policy statement that employees requiring licensure or certification must have current credentials in good standing or other required authorization to practice in the state in which they work. A section labeled procedure indicated in part employees with expired licenses or certificates are removed from the schedule and are not permitted to work until current licensure or certification is provided. The policy further indicated the employee would be returned to work upon receipt of documentation verifying active license or certification.</p> <p>A review of personnel files revealed Nurse Aide (NA) #6 was hired by the facility on 12/27/16. A document inside the file titled North Carolina Nurse Aide I Registry indicated the registry listing for NA #6 had expired and the listed expiration date was 01/31/17.</p> <p>During an interview on 02/10/17 at 1:54 PM with the Central Supply Clerk who was also responsible for the scheduling of Nurses and Nurse Aides (NAs) verified she was also responsible for managing the licensure and certifications reports for Nurses and NAs. She confirmed the North Carolina Nurse Aide I Registry listing indicated the NA certification for NA #6 had expired. She explained the computer system usually pulled a list of staff whose licenses or certifications were nearing expiration but she did not recall seeing NA #6's name on the previous months report and stated it may have been missed since NA #6 was hired near the end of December. She stated she usually called employees or talked to them in the facility when they needed to renew their license or certifications and she assisted them with completion of their paperwork as needed. She</p>	F 226	<p>certification for Nurse Aide #6 was reinstated into the Nursing Schedule at that time.</p> <p>Criteria 2</p> <ul style="list-style-type: none"> <li>All residents have the potential to be affected by this alleged deficient practice. An audit was conducted by the Scheduler on 2/23/17 to validate active Licensure and Certifications for current Nursing Staff. As a result of this audit no further expiration of license/certificate.</li> </ul> <p>Criteria 3</p> <ul style="list-style-type: none"> <li>On 2/23/17 the Scheduler was re-educated by the Administrator and Director of Nursing regarding the facility process for ensuring current Licensed and Certified Nursing Staff have active license/certifications in place prior to working in the resident care area. The Licensed and Certified Nursing Staff were re-educated by 3/10/17 by the Administrator, Director of Nursing or Nurse Managers on the expectation that a current license/certification is maintained and that a copy is provided to the facility. The current Nursing Staff will be re-educated by the Administrator, Director of Nursing or Nurse Managers regarding the facility's policy regarding Abuse and Neglect by 3/10/17.</li> <li>To prevent the alleged deficient practice from reoccurring the Scheduler and Director of Nursing will review the Nursing Schedule weekly for 12 weeks to validate all current staff scheduled to work the upcoming week have active license/certifications. Any staff identified with an opportunity with</li> </ul>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345221</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/10/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRIAN CENTER H &amp; REHAB WEAVERV</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>78 WEAVER BOULEVARD</b> <b>WEAVERVILLE, NC 28787</b>		
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F 226	<p>Continued From page 10</p> <p>explained she usually did the staff schedules for a month or two in advance and they had missed taking NA #6 off the schedules after her certification had expired.</p> <p>During an interview on 02/10/17 at 2:45 PM with the Area Staff Development Manager she verified NA #6's certification had expired on 01/31/17 but she had worked from 11:00 PM until 7:00 AM on 02/01/17, 02/02/17, 02/03/17 and 02/06/17. She explained the paperwork to renew NA #6's certification was mailed on Monday 02/06/17 to the North Carolina Nurse Aide I Registry and they were waiting for the renewal to be processed.</p> <p>During an interview on 02/10/17 at 3:53 PM with the Director of Nursing she explained NA #6 initially brought her application to the facility to renew her certification but the facility identification number had been left off and the application was returned to the facility as incomplete. She stated they had corrected the information and sent it back on 02/06/17 but NA #6 should not have been on the schedule to work with an expired certification.</p> <p>During an interview on 02/10/17 at 4:04 PM with the Administrator she stated it was her expectation NA #6 should not have been scheduled to work until the facility received confirmation that NA #6 had a current certification. She further stated it was crucial that staff check licenses and certifications to ensure they were not expired and the awareness had been heightened with facility staff.</p>	F 226	<p>license/certification renewal will be suspended immediately until corrected.</p> <p>Criteria 4</p> <ul style="list-style-type: none"> <li>To assure continued compliance with these processes, the DON will present the results of the weekly audit at the QAPI meeting each month x 3 months. The QAPI Committee will make recommendations based on the results of these audits.</li> </ul>		
F 241 SS=E	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241		3/10/17	

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F 241	<p>Continued From page 11</p> <p>(a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, record reviews, family interview and staff interviews, the facility failed to promote dignity during dining in the secured unit of the facility. This was evidenced by: a. in 1 of 2 dining rooms in the secured unit during 2 of 3 meal observations 2 residents were observed eating food from other residents' trays (Residents #66 and #152) in the designated dining room; and b. staff failed to promote dignity for 1 of 1 resident sampled in the secured unit for dignity issues when staff failed to change Resident #114's clothing and incontinent products when he was obviously soiled clothing prior to the meal tray delivery.</p> <p>The findings were:</p> <p>1. Resident #152 was admitted to the facility on 02/22/16 with diagnoses of Alzheimer's Disease, unspecified psychosis and anxiety. Her quarterly Minimum Data Set (MDS) dated 01/11/17 coded her with severely impaired cognition, having other behaviors 1 to 3 times in the previous 7 days and requiring limited assistance during eating.</p> <p>Resident #66 was admitted to the facility on 07/15/14 with diagnoses of Alzheimer's Disease, dementia with behavioral disturbances and anxiety. His quarterly MDS dated 01/12/17 coded him with severely impaired cognition, having other behaviors 1 to 3 days out of the previous 7 days</p>	F 241	<ul style="list-style-type: none"> <li>• On 2/11/17 the Director of Nursing and Nurse Managers offered Residents #66, #167, #137, #109 and #152 alternatives and additional portions to satisfy their needs following the breakfast meal.</li> <li>• On 2/9/17 the Nurse Aide and Charge Nurse provided incontinent care for Resident #114 following completion of the breakfast meal.</li> <li>• Staff who worked with the Residents #66, #167, #137, #109, and #152 were re-educated by the Director of Nursing and Nurse Managers regarding promoting dignity during meal time by ensuring appropriate supervision is provided to prevent sharing of food between residents, as well as providing incontinent care prior to meals by 3/10/17.</li> </ul> <p>Criteria 2</p> <ul style="list-style-type: none"> <li>• All residents requiring assistance with meals and incontinent care have the potential to be affected by this alleged deficient practice.</li> <li>• An observation of current residents during mealtimes was conducted by the Director of Nursing and Nurse Managers by 2/15/17. Resident care plans were revised by 3/10/17 to reflect these preferences and behaviors by the Director of Nursing and Nurse Managers</li> </ul>		

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F 241	<p>Continued From page 12 and requiring set up for eating.</p> <p>Resident #167 was readmitted to the facility on 11/23/16 with diagnoses of age related cognitive decline and dementia with behavioral disturbance. Her quarterly MDS dated 01/26/17 coded her with severely impaired cognition, having had delusions, having other behaviors 1 to 3 days out of the previous 7 and requiring set up for eating.</p> <p>During observations of the breakfast meal on 02/08/17, the cart of breakfast trays arrived on the secured unit at 7:33 AM. At 7:38 AM, Resident #167 was the first to be served. There were 2 other residents at her table, Resident #152 and Resident #66. At 7:39 AM, Resident #167 handed Resident #152, who was sitting directly across from her, her peanut butter and jelly sandwich. Resident #152 proceeded to eat the sandwich. At this time staff were observed prepping trays at the nursing station. At 7:41 AM, Resident #152 requested Resident #167 give her one of her drinks and Resident #167 gave Resident #152 her orange juice which Resident #152 proceeded to drink. At this time staff were observed still prepping breakfast trays at the nursing station and delivering trays to two other tables in the dining room, although neither Resident #152 nor Resident #66 had been served. On 02/08/17 at 7:46 AM, Nurse Aide (NA) #2 noticed Resident #152 eating food that had not been delivered to her. By this time 7 other residents at 2 different tables had been served since Resident #167 received her tray. Then at 7:47 AM, Resident #167 pushed her plate of eggs toward the middle of the table. Resident #152 then pushed the plate over in front of Resident #66 who proceeded to eat the eggs</p>	F 241	<p>as a result of these observations.</p> <ul style="list-style-type: none"> <li>Nursing Staff have been re-educated by the Director of Nursing and Nurse Managers regarding promoting dignity during meal time by ensuring appropriate supervision is provided to prevent sharing of food between residents, as well as providing incontinent care prior to meals by 3/10/17.</li> </ul> <p>Criteria 3</p> <ul style="list-style-type: none"> <li>Nursing Staff and Department Heads have been re-educated by the Director of Nursing and Nurse Managers with regards to promoting dignity during meal time and by ensuring appropriate supervision is provided to prevent sharing of food between residents, as well as providing incontinent prior to meals by 3/10/17. An "All Hands on Deck" approach has been implemented for facility meal service to increase supervision and monitoring during meals by 3/10/17. Extra food items are being sent out on all meal carts for 600 hall in order to offer additional servings to residents as needed by 3/10/17. Seating arrangements for dining rooms have also been evaluated and updated to streamline tray delivery by 3/10/17.</li> <li>A meal service audit will be completed and documented by a Nurse Manager 3 times per week for 12 weeks on varying shifts and days of the week to validate incontinent care needs are met prior to initiating meal service and adequate supervision is observed to promote dignity during meals.</li> </ul> <p>Criteria 4</p> <ul style="list-style-type: none"> <li>To assure continued compliance with</li> </ul>		

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F 241	<p>Continued From page 13</p> <p>with the fork of Resident #167. NA #1 intervened at 7:49 AM by replacing the plate of eggs with Resident #66's tray. Resident #152 received her tray at 7:49 AM.</p> <p>On 02/10/17 at 9:32 AM, NA #2 stated that during meals the aides normally assisted the residents who ate in the activity room and the nurse oversaw the residents in the dining room once they were served.</p> <p>Nurse #1 was interviewed on 02/10/17 at 9:43 AM. She stated that generally there were 2 nurse aides and herself on the unit. She stated it was her responsibility to observe the residents in the dining room who were more independent while nurse aides assisted those residents in the activity room. She stated that sometimes there was sharing of food especially with Resident #167.</p> <p>Interview with the Director of Nursing on 02/10/17 at 3:06 PM revealed there had been discussions related to the food service in the secured unit and trying to serve each table together. However, she stated the residents did not sit in the same seats each time to make it easy for dietary to load the trays in a specific order and therefore no system had been implemented. She stated the tray preparation time was longer in the secured unit. She further stated that other staff frequently visited the secured unit at meal times to assist. She stated that the nurse may not be able to observe sufficiently due to answering phones, passing medications assisting filling requests such as more coffee, etc. She stated it was on the list to get another nurse aide in the unit.</p> <p>2. Resident #152 was admitted to the facility on</p>	F 241	these processes, the DON will present results of the weekly meal service rounds at QAPI each month. The QAPI Committee will make recommendations as needed.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 241	<p>Continued From page 14</p> <p>02/22/16 with diagnoses of Alzheimer's Disease, unspecified psychosis and anxiety. Her quarterly Minimum Data Set (MDS) dated 01/11/17 coded her with severely impaired cognition, having other behaviors 1 to 3 times in the previous 7 days and requiring limited assistance during eating.</p> <p>Resident #66 was admitted to the facility on 07/15/14 with diagnoses of Alzheimer's Disease, dementia with behavioral disturbances and anxiety. His quarterly MDS dated 01/12/17 coded him with severely impaired cognition, having other behaviors 1 to 3 days out of the previous 7 days and requiring set up for eating.</p> <p>During dining observations made of the noon meal on 02/09/17, trays arrived to the secured unit at 12:23 PM. At this time Nurse Aides #1 and #2 were prepping trays at the nursing station and along with the activity assistant were delivering them to the dining room.</p> <p>At 12:45 PM, Resident #137 arrived to the dining room late and was served as the last in the room to receive their tray. Resident #137 attempted to eat the dessert and drank some of her milk. At 12:54 PM as Nurse #1 attempted to assist by feeding Resident #137, she got sick and was removed from the dining room. Her tray remained on the table where Resident #109 sat eating. At 1:01 pm, Resident #66 changed tables and sat at the table adjacent to Resident #109 and across from Resident #137's tray. At 1:04 PM, Resident #152 who was walking around the room attempting to clear trays, pushed Resident #137's tray toward Resident #66. At 1:05 PM, Resident #66 took some of the eaten bread crust from Resident #109's tray and ate it. There were no staff in the room at this time as the staff had</p>	F 241			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 241	<p>Continued From page 15</p> <p>moved to serve the residents who ate in the activity room. Then at 1:06 PM, with still no staff in the dining room, Resident #66 proceeded to pick up the partially drank milk off Resident #137's left tray and drank the half remaining glass of milk. At this time Nurse #1 was observed on the phone and the other staff were in the activity room.</p> <p>An interview with the Activity Assistant on 02/09/17 at 1:11 PM revealed he did not feed residents but assisted with the delivery of trays when nurse aides set them up and cleaning up. He further stated that while nurse aides assisted the more dependent residents in the activity room, the nurse was responsible for watching the residents left in the dining room.</p> <p>On 02/10/17 at 9:32 AM, NA #2 stated that during meals the aides normally assisted the residents who ate in the activity room and the nurse oversaw the residents in the dining room once they were served.</p> <p>Nurse #1 was interviewed on 02/10/17 at 9:43 AM. She stated that generally there were 2 nurse aides and herself on the unit. she stated it was her responsibility to observe the residents in the dining room who were more independent while nurse aides assisted those residents in the activity room. She stated that sometimes there was sharing of food.</p> <p>Interview with the Director of Nursing on 02/10/17 at 3:06 PM revealed that at the lunch meal and supper there was an activity assistant to help. She stated there had been discussions related to the food service in the secured unit and trying to serve each table together. However, she stated</p>	F 241			

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F 241	<p>Continued From page 16</p> <p>the residents did not sit in the same seats each time to make it easy for dietary to load the trays in a specific order and therefore no system had been implemented. She stated the tray preparation time was longer in the secured unit. She further stated that other staff frequently visited the secured unit at meal times to assist. She stated that the nurse may not be able to observe sufficiently due to answering phones, passing medications assisting filling requests such as more coffee, etc. She stated it was on the list to get another nurse aide in the unit.</p> <p>3. Resident #114 was admitted to the facility on 03/03/16. His diagnoses included dementia, restlessness and agitation, muscle weakness, and chronic pain syndrome.</p> <p>The annual Minimum Data Set dated 01/19/17 coded him with severely impaired cognition, verbal behaviors 1 to 3 times in previous 7 days, rejection of care 4 to 6 times in the previous 7 days, and having worse behaviors since the previous assessment. It was coded that he required extensive assistance with transfers, toileting and hygiene. He was also coded as being always incontinent of bowel and bladder.</p> <p>Review of the care plan related to actual urinary incontinence reviewed/revised on 01/28/17 had the goal that his dignity would be maintained with staff assistance for toileting needs and will remain clean and dry with staff intervention. The interventions included to assist to toilet every 2 hours and check and change on routine rounds every 2 to 3 hours as needed and to provide assistance as required for toileting, requiring extensive assistance of 1 to 2 staff.</p>	F 241			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 241	<p>Continued From page 17</p> <p>On 02/09/17 at 9:16 AM, family reported that Resident #114 was wet this morning and all staff did was change his gown and give him a clean blanket for his lap but that no one changed him for breakfast. He was sitting in a gerichair across from the nursing station at this time.</p> <p>On 02/09/17 at 9:34 AM, Nurse Aides (NA) #1 and #2 assisted Resident #114 to the shower room and proceeded to assist him to the commode. Resident #114 stood and was noted to have the blanket upon which he was sitting soaked with urine and his pants and brief were soaked with urine. When the NAs were asked about the last time he was checked and toileted, they responded that they had not checked or toileted him since coming on at 7:00 AM. NA #1 and NA #2 stated after care was complete at 9:48 AM that Resident #114 often refused care for them and that if you push the issue he got agitated.</p> <p>On 02/09/17 at 10:11 AM Nurse #1 stated during interview that as staff were passing the breakfast trays, she noticed that Resident #114's gown was wet. She stated that she could not provide the care herself so she wanted to make him as comfortable as possible and change his gown and blanket and then he received his breakfast tray.</p> <p>Upon follow up interview on 02/10/17 at 1:30 PM, Nurse #1 stated Resident #114's gown had been wet about 6 inches in diameter around the left front of his stomach. She stated she assumed it was urine. She stated he required 2 persons to transfer and staff were passing trays so she decided to try and make him as comfortable as she could. Resident #114 was known to urinate</p>	F 241			

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F 241	Continued From page 18 excessively due to his diuretic use and refused care at times.  A follow up interview with NA #1 on 02/10/17 at 1:38 PM revealed that when staff arrived at 7 AM on 02/09/17, they offered to get him dressed. He stated no. Staff further stated he was more cooperative with family around.  Interview with the Director of Nursing on 02/10/17 at 3:00 PM revealed she expected staff to check residents for incontinence prior to meal services. She further stated that if a resident was visibly wet at the meal, she would want that resident changed and not sitting and eating soiled.	F 241			
F 246 SS=D	483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES  (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident, family and staff interviews the facility failed to put a hearing aid in place which limited the residents' ability to hear for 1 of 2 residents sampled to make reasonable accommodations of resident's needs (Resident #54).  Findings included:  Resident #54 was re-admitted to the facility on 10/19/14 with diagnoses which included congestive heart failure, chronic heart disease, chronic respiratory failure, type 2 diabetes,	F 246	Criteria 1 • Resident #54 had hearing aids placed by the CNA on 2/11/17. Validation of hearing aid placement has been added to the medication administration record on 2/12/17 by the Nurse Manager for Resident #54 requiring a signature from the Charge Nurse verifying the hearing aid is in and working daily. Criteria 2 • Current Residents requiring assistance with hearing aid placement have the potential to be affected by this	3/10/17	

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F 246	<p>Continued From page 19</p> <p>generalized muscle weakness, a lack of coordination and macular degeneration (a deterioration in the eye causing distortion or vision loss in the center of the eye).</p> <p>A review of the most recent quarterly Minimum Data Set (MDS) dated 01/13/17 indicated Resident #54 was severely impaired in cognition for daily decision making and required limited assistance with activities of daily living (ADLs).</p> <p>A review of a care plan revised on 01/04/17 titled ADL self-care performance deficit related to weakness revealed in part Resident #54 needed assistance from staff for ADLs due to impaired vision. The goal indicated Resident #54 would maintain current level of function and interventions were listed in part to encourage Resident #54 to actively participate in tasks and provide cueing with tasks as needed.</p> <p>A review of a facility document titled Resident Care Specialist Assignment Sheet dated 02/08/17 in a section for special needs and instructions indicated hearing aids for Resident #54.</p> <p>During a telephone interview with a family member on 02/07/17 at 2:11 PM she expressed concerns that when she visited Resident #54 on a weekly basis Resident #54 did not have her hearing aid in place. She stated she had reminded staff to put Resident #54's hearing aid in for her because she could not see to do it herself. She further stated she would like to see staff routinely put the hearing aid in each morning for Resident #54 since she could not do it herself.</p> <p>During an observation on 02/08/17 at 7:21 AM Resident #54 was sitting in a wheelchair in the</p>	F 246	<p>alleged deficient practice. An audit was conducted 2/16/17 by the Medical Record Manager to identify residents who currently utilize hearing aids and require assistance with placement. The Nurse Managers have updated the Resident's care plan to reflect assistance required with hearing aid placement and have updated the medication administration record to include daily validation of hearing aid placement by 3/10/17.</p> <p>Criteria 3</p> <ul style="list-style-type: none"> <li>Nursing Staff were re-educated by the Administrator, DON &amp; Nurse Managers regarding assisting residents with hearing aid placement as part of the daily routine. Nurse Managers will randomly audit Residents with hearing aids to validate assistance with placement 3 times per week for 12 weeks on varying shifts and days of the week. Opportunities will be corrected immediately as identified.</li> </ul> <p>Criteria 4</p> <ul style="list-style-type: none"> <li>To assure continued compliance with these processes, the DON will present audit results at the QAPI meetings monthly for three months. QAPI Committee will make recommendations as needed changes in the POC.</li> </ul>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER  <b>BRIAN CENTER H &amp; REHAB WEAVERV</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>78 WEAVER BOULEVARD</b> <b>WEAVERVILLE, NC 28787</b>		
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F 246	<p>Continued From page 20</p> <p>doorway of her room and had no hearing aid in place.</p> <p>During an observation on 02/08/17 at 10:05 AM Resident #54 was sitting in the hallway in a wheelchair next to a linen cart and had no hearing aid in place.</p> <p>During an observation on 02/08/17 at 11:10 AM Resident #54 was seated in a wheelchair in the main dining room at a table with 2 other residents. Resident #54 was not talking with the residents seated at the table and there was no hearing aid in place.</p> <p>During an observation on 02/08/17 at 4:35 PM during a medication pass revealed Resident #54 did not have a hearing aid in place and stated the battery had fallen out the night before.</p> <p>During an observation on 02/09/17 at 10:22 AM Resident #54 was sitting in a wheelchair in the doorway of her room and there was no hearing aid in place.</p> <p>During an observation and interview on 02/10/17 at 10:15 AM Resident #54 was seated in a wheelchair in her room. Resident #54 did not have a hearing aid in place and leaned over very close during the interview so she could hear. She explained she wore a hearing aid in her left ear but it was hard for her to get it adjusted and fixed in her ear because she couldn't see well. She further explained she took her hearing aid out at night when she went to bed and the other night the battery fell out and she couldn't find it. Resident #54 verified she did not have her hearing aid in place yesterday or the day before. She stated she had worn a hearing aid for the last</p>	F 246			

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F 246	<p>Continued From page 21</p> <p>2-3 years and it was very important for her to be able to hear because if someone's voice was low she couldn't hear them. She explained it was her preference each morning to go eat breakfast in the dining room and then have her hearing aid put in when she went back to her room. She stated she needed the staff to help her put the hearing aid in but staff were busy and usually forgot to put it in for her. She explained the battery for her hearing aid was stored in a separate compartment in the hearing aid box. She further explained it was very difficult for her to see to put the battery in the hearing aid because they were so small and she usually dropped the battery and then couldn't find it. She stated it was her preference to have her hearing aide in every day so she could hear.</p> <p>During an interview on 02/10/17 at 11:06 AM with Nurse Aide #7 she verified she was assigned to care for Resident #54. She explained it was Resident #54's morning routine to get up and get herself dressed. She stated sometimes Resident #54 put her hearing aide in herself but she usually needed assistance because it was hard for her to put it in by herself. She confirmed she had forgotten to put Resident #54's hearing aid in that morning and did not recall if she had put her hearing aid in yesterday. She stated it made a big difference when Resident #54 had her hearing aide in because when she gave her a shower NA #7 felt like she had to yell at Resident #54 so she could hear her. She further stated it was like night and day when Resident #54 had her hearing aid in because she could hear so much better when it was in her ear. NA #7 verified Resident #54 only wore 1 hearing aid and she was very particular about how it fit under the earpiece of her glasses.</p>	F 246			

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F 246	Continued From page 22  During an interview on 02/10/17 at 1:45 PM with Medication Technician #1 she stated staff usually put Resident #54's hearing aid in when she asked staff to do it for her. She further stated she did not recall when she had last seen Resident #54's hearing aid in place.  During an interview on 02/10/17 at 2:13 PM with Nurse #8 she verified Resident #54 wore a hearing aide in her left ear. She explained on some days Resident #54 put her hearing aid in by herself and some days she asked for help because it depended on what she could accomplish for that day. She explained the Nurse Aides (NAs) had a care sheet for each resident they were assigned to care for and were supposed to review them to make sure everything was done and nurses were expected to follow up and make sure things were done.  During an interview on 02/10/17 at 3:53 PM with the Director of Nursing she confirmed Resident #54 had a hearing aid and it was her expectation for staff to check that it was in place each day.  During an interview on 02/10/17 4:24 PM with the Administrator she stated it was her expectation for staff to accommodate resident's needs and the resident should get the assistance they needed.	F 246			
F 253 SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES  (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced	F 253		3/10/17	

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F 253	<p>Continued From page 23</p> <p>by: Based on observations and staff interviews the facility failed to repair smoke prevention doors on the main hallway next to the lobby with a strip of metal that was bent and was sticking outward with a sharp edge at the bottom of the door, failed to repair the smoke prevention doors with broken and splintered laminate and wood on the main hall near the nurses station at 200/400 halls, on the 200 hall and on the 400 hall; failed to repair the main dining room door with broken and splintered laminate and wood on the lower edges of the door; failed to repair 2 doors into the therapy department with broken and splintered laminate and wood on the lower edges of the doors; failed to repair 20 resident room doors with broken and splintered laminate and wood on the lower edges of the doors (Room #111, #112, #405, #410, #411, #412, #414, #601, #602, #603, #604, #605, #610, #611, #613, #614, #615, #616, #617 and #618) on 3 of 5 resident hallways; failed to repair broken and loose laminate at closets in Room #615 and #617 and failed to repair stained and cracked grout around toilets in 4 resident bathrooms (Room #410, #412 and #609 and #618) on 2 of 5 resident hallways.</p> <p>The findings included:</p> <p>1. Observations on 02/07/17 at 10:45 AM of the smoke prevention doors on the main hallway next to the lobby revealed a metal strip that was bent and was sticking outward with a sharp edge at the bottom of the door. Observations on 02/08/17 at 11:00 AM of the smoke prevention doors on the main hallway next to the lobby revealed a metal strip that was bent and was sticking outward with a sharp edge at the bottom of the door.</p>	F 253	<p>"Corrective action has been accomplished for the alleged deficient practice with regards to environmental issues identified in the 2567. The metal strip that was bent and sticking out on the front smoke prevention doors was repaired on 2/14/17. The smoke prevention doors with broken and splintered laminate near the 200/400 nurses station will be repaired by covering with FRP and edge protect guards by 3/10/17. The main dining room door with broken and splintered laminate will be repaired by covering with FRP and edge protect guards by 3/10/17. The two entry doors to the therapy department will be repaired by covering with FRP and edge protect guards by 3/10/17. Door surfaces for room #111, #112, #405, #410, #411, #412, #414, #604, #611, #613, and #615 will be covered with FRP vinyl and door edges will be covered with edge protect guards by 3/10/17. Door surfaces for #601, #602, #603, #605, #610, #614, #616, #617, and #618 will be covered with edge protect guards by 3/10/17. For the broken and loose laminate on closets of room #615 and #617, the closets will be replaced. The new closets were ordered on 3/1/17. The bathroom floor in #410, #412, and #609 will be cleaned, stripped, waxed, and caulked by 3/10/17. The bathroom floor in 618 will have cracked tile replaced and be cleaned, stripped, waxed, and caulked by 3/10/17. These repairs will be completed by the Maintenance Director or designee. " Other areas of the facility have the</p>		

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F 253	<p>Continued From page 24</p> <p>Observations on 02/09/17 at 9:30 AM of the smoke prevention doors on the main hallway next to the lobby revealed a metal strip that was bent and was sticking outward with a sharp edge at the bottom of the door.</p> <p>b. Observation on 02/07/17 at 10:40 AM of smoke prevention doors on the main hall near the nurses station at 200/400 halls revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch. Observation on 02/08/17 at 10:47 AM of smoke prevention doors on the main hall near the nurses station at 200/400 halls revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch. Observation on 02/09/17 at 9:37 AM of smoke prevention doors on the main hall near the nurses station at 200/400 halls revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p> <p>c. Observation on 02/07/17 at 11:11 AM of smoke prevention doors on the 200 hall revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch. Observation on 02/08/17 at 10:50 AM of smoke prevention doors on the 200 hall revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch. Observation on 02/09/17 at 9:40 AM of smoke prevention doors on the 200 hall revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch</p> <p>d. Observation on 02/07/17 at 10:42 AM of smoke prevention doors on the 400 hall revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p>	F 253	<p>potential to be affected by the same alleged deficient practice. An audit was conducted on 2-14-17 by the Maintenance Director which identified that all resident room door edges contain chipped or broken areas. These doors will all be repaired by applying edge protect guards by 3/10/17. In addition to resident room doors, we identified living room doors, 600 hall nurses station doors, 600 hall smoke prevention doors, and 600 hall shower room door that also have broken or chipped edges and will be repaired with edge protect guards by 3/9/17. The audit did not identify additional veneer strips, metal strips on doors. The audit identified 4 additional bathroom floors in #104, #105, and #203 that are in disrepair and the floor covering will be replaced by 3/9/17. Room #409 will be cleaned, and/or stripped, waxed, and caulk by 3/9/17. The audit did not identify additional veneer strips, metal strips on doors. An audit was completed to identify closets in disrepair on 3/1/17. Two additional closets in #102 and #409 were identified for replacement. Theses closets will be ordered by 3/2/17. The work will be completed by the Maintenance Director or designee.</p> <p>" To prevent the alleged deficient practice from reoccurring the Administrator and the DON provided staff education conducted on 2/15/17 to review the environmental deficiency. Staff was instructed to use the repair request forms at the nurse's station to alert the Maintenance Director of any needed repairs. Environmental rounds will be</p>		

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F 253	<p>Continued From page 25</p> <p>Observation on 02/08/17 at 10:50 AM of smoke prevention doors on the 400 hall revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch</p> <p>Observation on 02/09/17 at 9:40 AM of smoke prevention doors on the 400 hall revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch</p> <p>2. Observation on 02/07/17 at 10:30 AM of the main dining room door revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p> <p>Observations on 02/08/17 at 10:45 AM of the main dining room door revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p> <p>Observations on 02/09/17 at 9:35 AM of the main dining room door revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p> <p>3. Observation on 02/07/17 at 10:35 AM of 2 doors into the therapy department revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p> <p>Observation on 02/08/17 at 10:47 AM of 2 doors into the therapy department revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p> <p>Observation on 02/09/17 at 9:37 AM of 2 doors into the therapy department revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p> <p>4. a. Observation on 02/07/17 at 10:43 AM of the door on resident room #111 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p>	F 253	<p>conducted by Administrator or designee weekly x 90 days to identify additional environmental issues and verify that previous issues reported remain in good repair.</p> <p>" To assure continued compliance with these processes, the Maintenance Director will present results of the weekly environmental rounds at QAPI each month. The QAPI Committee will recommend any needed changes to the POC.</p>		

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F 253	<p>Continued From page 26</p> <p>Observation on 02/08/17 at 10:51 AM of the door on resident room #111 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p> <p>Observation on 02/09/17 at 9:41 AM of the door on resident room #111 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p> <p>b. Observation on 02/07/17 at 10:44 AM of the door on resident room #112 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p> <p>Observation on 02/08/17 at 10:52 AM of the door on resident room #112 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p> <p>Observation on 02/09/17 at 9:42 AM of the door on resident room #112 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p> <p>c. Observation on 02/07/17 at 10:45 AM of the door on resident room #405 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p> <p>Observation on 02/08/17 at 10:52 AM of the door on resident room #405 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p> <p>Observation on 02/09/17 at 9:42 AM of the door on resident room #405 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p> <p>d. Observation on 02/07/17 at 10:46 AM of the door on resident room #410 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p>	F 253			

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F 253	<p>Continued From page 27</p> <p>Observation on 02/08/17 at 10:53 AM of the door on resident room #410 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p> <p>Observation on 02/09/17 at 9:43 AM of the door on resident room #410 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p> <p>e. Observation on 02/07/17 at 10:47 AM of the door on resident room #411 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p> <p>Observation on 02/08/17 at 10:54 AM of the door on resident room #411 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p> <p>Observation on 02/09/17 at 9:44 AM of the door on resident room #411 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p> <p>f. Observation on 02/07/17 at 10:48 AM of the door on resident room #412 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p> <p>Observation on 02/08/17 at 10:55 AM of the door on resident room #412 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p> <p>Observation on 02/09/17 at 9:45 AM of the door on resident room #412 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p> <p>g. Observation on 02/07/17 at 10:49 AM of the door on resident room #414 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p>	F 253			

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F 253	Continued From page 28 Observation on 02/08/17 at 10:57 AM of the door on resident room #414 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch. Observation on 02/09/17 at 9:45 AM of the door on resident room #414 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.  h. Observation on 02/07/17 at 11:45 AM of the door on resident room #601 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch. Observation on 02/08/17 at 11:01 AM of the door on resident room #601 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch. Observation on 02/09/17 at 9:55 AM of the door on resident room #601 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.  i. Observation on 02/07/17 at 11:46 AM of the door on resident room #602 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch. Observation on 02/08/17 at 11:02 AM of the door on resident room #602 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch. Observation on 02/09/17 at 9:56 AM of the door on resident room #602 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.  j. Observation on 02/07/17 at 11:47 AM of the door on resident room #603 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.	F 253			

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F 253	<p>Continued From page 29</p> <p>Observation on 02/08/17 at 11:03 AM of the door on resident room #603 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p> <p>Observation on 02/09/17 at 9:57 AM of the door on resident room #603 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p> <p>k. Observation on 02/07/17 at 11:48 AM of the door on resident room #604 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p> <p>Observation on 02/08/17 at 11:04 AM of the door on resident room #604 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p> <p>Observation on 02/09/17 at 9:58 AM of the door on resident room #604 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p> <p>l. Observation on 02/07/17 at 11:49 AM of the door on resident room #605 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p> <p>Observation on 02/08/17 at 11:05 AM of the door on resident room #605 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p> <p>Observation on 02/09/17 at 9:59 AM of the door on resident room #605 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p> <p>m. Observation on 02/07/17 at 11:50 AM of the door on resident room #610 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p>	F 253			

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F 253	<p>Continued From page 30</p> <p>Observation on 02/08/17 at 11:07 AM of the door on resident room #610 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p> <p>Observation on 02/09/17 at 10:01 AM of the door on resident room #610 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p> <p>n. Observation on 02/07/17 at 11:51 AM of the door on resident room #611 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p> <p>Observation on 02/08/17 at 11:08 AM of the door on resident room #611 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p> <p>Observation on 02/09/17 at 10:02 AM of the door on resident room #611 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p> <p>o. Observation on 02/07/17 at 11:52 AM of the door on resident room #613 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p> <p>Observation on 02/08/17 at 11:09 AM of the door on resident room #613 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p> <p>Observation on 02/09/17 at 10:03 AM of the door on resident room #613 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p> <p>p. Observation on 02/07/17 at 11:53 AM of the door on resident room #614 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p>	F 253			

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F 253	<p>Continued From page 31</p> <p>Observation on 02/08/17 at 11:10 AM of the door on resident room #614 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p> <p>Observation on 02/09/17 at 10:04 AM of the door on resident room #614 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p> <p>q. Observation on 02/07/17 at 11:54 AM of the door on resident room #615 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p> <p>Observation on 02/08/17 at 11:12 AM of the door on resident room #615 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p> <p>Observation on 02/09/17 at 10:05 AM of the door on resident room #615 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p> <p>r. Observation on 02/07/17 at 11:55 AM of the door on resident room #616 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p> <p>Observation on 02/08/17 at 11:13 AM of the door on resident room #616 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p> <p>Observation on 02/09/17 at 10:06 AM of the door on resident room #616 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p> <p>s. Observation on 02/07/17 at 11:56 AM of the door on resident room #617 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.</p>	F 253			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 253	Continued From page 32 Observation on 02/08/17 at 11:15 AM of the door on resident room #617 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch. Observation on 02/09/17 at 10:08 AM of the door on resident room #617 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.  t. Observation on 02/07/17 at 11:57 AM of the door on resident room #618 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch. Observation on 02/08/17 at 11:16 AM of the door on resident room #618 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch. Observation on 02/09/17 at 10:10 AM of the door on resident room #618 revealed broken and splintered laminate and wood on the lower edges of the door that were rough to touch.  6. a. Observation on 02/07/17 at 11:54 AM in resident room #615 revealed missing laminate at the closet with rough edges to the touch. Observation on 02/08/17 at 11:12 AM in resident room #615 revealed missing laminate at the closet with rough edges to the touch. Observation on 02/09/17 at 10:05 AM in resident room #615 revealed missing laminate at the closet with rough edges to the touch.  b. Observation on 02/07/17 at 11:56 AM in resident room #617 revealed loose laminate at the closet. Observation on 02/08/17 at 11:15 AM in resident room #617 revealed loose laminate at the closet. Observation on 02/09/17 at 10:08 AM in resident room #617 revealed loose laminate at the closet.	F 253			

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F 253	Continued From page 33  7. a. Observation on 02/07/17 at 10:46 AM in the bathroom of resident room #410 revealed stained and cracked grout around the base of the toilet. Observation on 02/08/17 at 10:53 AM in the bathroom of resident room #410 revealed stained and cracked grout around the base of the toilet. Observation on 02/09/17 at 9:43 AM in the bathroom of resident room #410 revealed stained and cracked grout around the base of the toilet.  b. Observation on 02/07/17 at 10:48 AM in the bathroom of resident room #412 revealed stained and cracked grout around the base of the toilet. Observation on 02/08/17 at 10:55 AM in the bathroom of resident room #412 revealed stained and cracked grout around the base of the toilet. Observation on 02/09/17 at 9:45 AM in the bathroom of resident room #412 revealed stained and cracked grout around the base of the toilet.  c. Observation on 02/07/17 at 11:50 AM in the bathroom of resident room #609 revealed stained and cracked grout around the base of the toilet. Observation on 02/08/17 at 11:05 AM in the bathroom of resident room #609 revealed stained and cracked grout around the base of the toilet. Observation on 02/09/17 at 10:01 AM in the bathroom of resident room #609 revealed stained and cracked grout around the base of the toilet.  d. Observation on 02/07/17 at 11:57 AM in the bathroom of resident room #618 revealed stained and cracked grout around the base of the toilet. Observation on 02/08/17 at 11:16 AM in the bathroom of resident room #618 revealed stained and cracked grout around the base of the toilet. Observation on 02/09/17 at 10:10 AM in the bathroom of resident room #618 revealed stained	F 253			

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F 253	<p>Continued From page 34 and cracked grout around the base of the toilet.</p> <p>During an interview and environmental tour on 02/10/17 at 4:31 PM with the Maintenance Director he explained the facility used a work order system and there was a mailbox at each nurse's station for staff to put the work orders in and he checked them during rounds each day. He stated he did not have an assistant but he utilized a vendor who provided a handy man to help as needed. He explained staff also stopped him as he made rounds to report things that needed to be fixed. He stated he was not aware of the metal strip that was bent on the bottom of the smoke prevention doors on the main hallway near the lobby. He further stated the chipped laminate and wood on the lower edges of smoke prevention doors, main dining room door, therapy doors and resident room doors had been damaged by wheelchairs. He explained they had put protective covers on some doors but the edges still took a beating and he would have to figure out a solution to the problem. He stated he had received no work orders regarding the stained and cracked grout around the base of toilets in resident bathrooms. He further stated he expected for staff to report anything that did not look normal and if in doubt they should still report it.</p> <p>During an interview on 02/10/17 at 5:25 PM with the Administrator who was also present during the environmental tour explained she also made rounds daily and sent text messages to the Maintenance Director or completed work orders when she saw things that needed repair. She further explained other Administrative Managers made rounds and they had Ambassadors who made rounds and stated it was her expectation</p>	F 253			

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F 253	Continued From page 35 for staff to report damage to doors and any other repairs that needed to be made.	F 253			
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS  (b) Comprehensive Assessments  (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:  (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the  care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must	F 272		3/10/17	

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F 272	<p>Continued From page 36</p> <p>include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.</p> <p>The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a Care Area Assessment that addressed the individual underlying causes, contributing factors and risk factors for 13 of 26 sampled residents. The areas not comprehensively assessed included cognition, incontinence, behaviors, falls, psychotropic medications and delirium and included Residents #21, #44, #114, #117, #150, #153, #155, #198 #54.</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>Resident #114 was admitted to the facility on 03/03/16. His diagnoses included dementia, restlessness and agitation, muscle weakness, and chronic pain syndrome.</li> </ol> <p>The annual Minimum Data Set (MDS) dated 01/19/17 coded him with severely impaired cognition, verbal behaviors 1 to 3 times in previous 7 days, rejection of care 4 to 6 times in the previous 7 days, and having worse behaviors since the previous assessment. It was coded that he required extensive assistance with</p>	F 272	<p>Corrective action was accomplished for the alleged deficient practice for residents #114, 155, 21, 153, 150, 44, 198, 52, 100, 56, 58 and 54 by the RCMD setting ARD for a Significant Correction to Prior Comprehensive Assessment to include updated CAAs by 2/27/17. Resident #54 was identified as a significant change with significant change in status assessment MDS scheduled with an ARD of 2/17/17. MDS assessments will be completed per the RAI manual guidelines by the RCMD or MDS coordinator. Resident #117 expired on 2/26/17 so no corrective action taken.</p> <p>All residents who have received a comprehensive MDS assessment have the potential to be affected by the alleged deficient practice. The RCMD or designee will complete an audit of all current residents receiving a comprehensive assessment during the last 14 days to verify accurate CAA completion per the RAI manual</p>		

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F 272	<p>Continued From page 37</p> <p>transfers, toileting and hygiene. He was also coded as being always incontinent of bowel and bladder.</p> <p>Review of the Care Area Assessments (CAA) revealed that the information was provided via a checklist and narrative that repeated the MDS information but did not analyze the information as to how the information gathered affected Resident #114 as follows:</p> <p>a. The Cognitive Loss/Dementia CAA dated 01/25/17 noted Resident #114 had a score of 3 on the Brief Interview for Mental Status, Had a diagnoses of dementia, chronic obstructive pulmonary disease, heart failure, anxiety and depression, had abusive language and rejection of care, had reports of pain, used a gerichair, and had impaired vision. The rationale for care planning to care plan for cognitive loss/dementia was related to current status, diagnosis and potential influences.</p> <p>b. The Urinary Incontinence CAA dated 01/25/17 noted Resident #114 had urinary incontinence and required assist with toileting, had diagnoses including heart failure, depression, and anxiety and reported pain. He required assist with bed mobility, transfers, walking and locomotion. He received a diuretic, antidepressant, antianxiety and hypnotic which were listed by drug name only. The rationale for proceeding to care planning for urinary incontinence was related to current status, diagnosis and potential influences.</p> <p>c. The Behavioral Symptom CAA dated 01/25/17 noted Resident #114 had rejection of care and abusive language, had diagnoses of heart failure and dementia, and reported pain. He had impaired vision. The rationale for proceeding to care planning for behavioral symptoms was related to current status, diagnoses and potential</p>	F 272	<p>guidelines. Resident with MR number 2015583 was identified in the audit and a correction will be completed by the RCMD or MDS Coordinator with an ARD date of 2/24/17. Resident 2015587 was identified in the audit and a correction is scheduled to be completed by the RCMD or MDS with an ARD date of 3/3/17. This audit will be completed by 2/22/17.</p> <p>The District Director of Care Management will re- educate the resident care management director on accurate CAA completion per the RAI manual guidelines by 2/28/17. The RCMD will re- educate the MDS coordinators and any other IDT members that are completing CAAs on accurate CAA completion per the RAI manual guidelines by 2/28/17. The RCMD or designee will randomly audit 5 comprehensive MDS assessments per week for 12 weeks to verify accurate CAA completion per the RAI manual guidelines. Once compliance is achieved, RCMD will audit 1 completed MDS each week for 4 weeks. If no additional issues are identified, the RCMD will then audit 2 completed MDS each month on an ongoing basis. Opportunities will be corrected as identified.</p> <p>The results of these audits will be submitted to the QAPI committee by the RCMD for review by the QAPI committee each month. The QAPI committee will evaluate effectiveness and amend as needed.</p>		

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F 272	<p>Continued From page 38 influences.</p> <p>Interview with the MDS Coordinator/Supervisor on 02/10/17 at 5:40 PM revealed the MDS staff who completed this CAA had left for the day. MDS Coordinator/Supervisor stated that the CAA should check or note any and all information, facts not opinions, gathered from the MDS that may have some effect on the care area. She further stated that she was trained that all the information on the MDS was what was included in the CAA and the analysis was the decision to proceed to care for the reasons listed in that section. She stated she was unaware that there should be some analysis describing the individual resident.</p> <p>Interview with the Director of Nursing on 02/10/2017 at 6:53 PM revealed she expected the MDSs to be accurate and the CAAs to paint a picture of the resident and be individualized so the reader could follow the thought process to provide appropriate care.</p> <p>2. Resident #155 was admitted to the facility 01/20/17 with diagnoses including encephalopathy, dementia with lewy bodies, visual hallucinations, and lack of coordination.</p> <p>The admission Minimum Data Set (MDS) dated 01/27/17 coded him with severely impaired cognition, having other behaviors 1 to 3 days in the previous 7, rejecting care 1 to 3 days in the previous 7, and wandering 4 to 6 days out of the previous 7 days. He was coded as needing limited assistance for bed mobility, transfers and walking.</p> <p>Review of the Care Area Assessments (CAA)</p>	F 272			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345221</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/10/2017</b>
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F 272	<p>Continued From page 39</p> <p>revealed that the information was provided via a checklist and narrative that repeated the MDS information but did not analyze the information as to how the information gathered affected Resident #155 as follows:</p> <p>a. The Cognition/Dementia CAA dated 01/30/17 noted Resident #155 scored 0 on the Brief Interview for Mental Status, had diagnoses of dementia, hypothyroidism, heart failure and chronic kidney disease, and usually understood and usually understands. He had wandering, rejection of care, repeated movements and yelling behaviors and used a hearing aide to the left ear. The rationale for proceeding to care planning was related to current status, diagnosis and potential influences.</p> <p>b. The Behavioral Symptoms CAA dated 01/30/17 noted Resident #155 had yelling, rejection of care, wandering and repeated movements in the look back period. He had diagnoses of heart failure, and dementia. The rationale for proceeding to care planning behaviors was related to current status, diagnosis, and potential influences.</p> <p>Interview with the MDS Coordinator/Supervisor on 02/10/17 at 5:40 PM revealed the MDS staff who completed this CAA had left for the day. MDS Coordinator/Supervisor stated that the CAA should check or note any and all information, facts not opinions, gathered from the MDS that may have some effect on the care area. She further stated that she was trained that all the information on the MDS was what was included in the CAA and the analysis was the decision to proceed to care for the reasons listed in that section. She stated she was unaware that there should be some analysis describing the individual resident.</p>	F 272			

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F 272	<p>Continued From page 40</p> <p>Interview with the Director of Nursing on 02/10/2017 at 6:53 PM revealed she expected the MDSs to be accurate and the CAAs to paint a picture of the resident and be individualized so the reader could follow the thought process to provide appropriate care.</p> <p>3. Resident #21 was admitted to the facility on 09/30/15. Her diagnoses included Alzheimer's Disease, dementia, hypertension, unstable angina, anxiety and insomnia.</p> <p>The annual Minimum Data Set (MDS) dated 08/18/16 coded her with moderate hearing loss, usually understanding and being understood, having severely impaired cognition, requiring supervision for walking, dressing, bed mobility, transfers, toileting and hygiene. She was coded as always being steady with transitions and having one fall with no injury since prior assessment.</p> <p>Review of the Care Area Assessments (CAA) revealed that the information was provided via a checklist and narrative that repeated the MDS information but did not analyze the information as to how the information gathered affected Resident #21 as follows:</p> <p>a. The Cognitive/Dementia CAA dated 08/22/16 stated she scored 3 out of 15 on the Brief Interview for Mental Status (BIMS) and usually understood and usually understands. She had diagnoses including Alzheimer's disease, dementia anxiety, depression and coronary artery disease and had wandering and repetitive movements. The CAA listed one medication she received, an anticonvulsive medication by name only and also stated she used a cane and had</p>	F 272			

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F 272	<p>Continued From page 41</p> <p>impaired hearing. The rationale for proceeding to care planning was related to current status, diagnosis and potential influences.</p> <p>b. The Falls CAA dated 08/22/16 stated she had a fall on 07/02/16, had wandering behaviors, and received 4 medications (named only). The CAA further listed her diagnoses, noted she had impaired hearing and wandering behaviors and noted her BIMS score was 3. The rationale for proceeding to care planning for falls was related to current status, diagnosis, and potential influences.</p> <p>Interview with the MDS Coordinator/Supervisor on 02/10/17 at 5:40 PM revealed the MDS staff who completed this CAA had left for the day. MDS Coordinator/Supervisor stated that the CAA should check or note any and all information, facts not opinions, gathered from the MDS that may have some effect on the care area. She further stated that she was trained that all the information on the MDS was what was included in the CAA and the analysis was the decision to proceed to care for the reasons listed in that section. She stated she was unaware that there should be some analysis describing the individual resident.</p> <p>Interview with the Director of Nursing on 02/10/2017 at 6:53 PM revealed she expected the MDSs to be accurate and the CAAs to paint a picture of the resident and be individualized so the reader could follow the thought process to provide appropriate care.</p> <p>4. Resident #117 was admitted to the facility on 07/23/13. Her diagnoses included Alzheimer's disease, chronic obstructive pulmonary disease, hypertension and anxiety.</p>	F 272			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 272	Continued From page 42  The annual Minimum Data Set (MDS) dated 10/28/16 coded Resident #21 with severely impaired cognition, requiring limited assistance with bed mobility, transfers, and walking. She was coded as being unsteady during transitions but able to stabilize herself without assistance. She was noted to have one fall with no injury since the prior assessment.  Review of the Care Area Assessments (CAA) revealed that the information was provided via a checklist and narrative that repeated the MDS information but did not analyze the information as to how the information gathered affected Resident #117 as follows: a. The Cognitive/Dementia CAA dated 11/01/16 stated she scored 3 on the Brief Interview for Mental Status and exhibited disorganized thinking, was usually understood and usually understands. The CAA noted her diagnoses of Alzheimer's Disease, anxiety, depression, diabetes and heart failure. It was noted she had dental pain, received oxygen therapy and had impaired vision. The rationale for proceeding to care planning for cognition was related to current status, diagnosis, and potential influences. b. The Falls CAA dated 11/01/16 noted she had an actual fall on 09/12/16, required assistance with transfers and walking. The CAA also listed medications by name received during the look back period and diagnoses. It was noted that she reported pain and had impaired hearing. The rationale for proceeding to care plan for falls was related to current status, diagnosis, and potential influences.  Interview with the MDS Coordinator/Supervisor on 02/10/17 at 5:40 PM revealed the MDS staff	F 272			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 272	<p>Continued From page 43</p> <p>who completed this CAA had left for the day. MDS Coordinator/Supervisor stated that the CAA should check or note any and all information, facts not opinions, gathered from the MDS that may have some effect on the care area. She further stated that she was trained that all the information on the MDS was what was included in the CAA and the analysis was the decision to proceed to care for the reasons listed in that section. She stated she was unaware that there should be some analysis describing the individual resident.</p> <p>Interview with the Director of Nursing on 02/10/2017 at 6:53 PM revealed she expected the MDSs to be accurate and the CAAs to paint a picture of the resident and be individualized so the reader could follow the thought process to provide appropriate care.</p> <p>5. Resident #153 was admitted to the facility on 05/06/16. His diagnoses included chronic pain syndrome, Huntington's Disease, dementia, difficulty walking and hypertension.</p> <p>The admission Minimum Data Set (MDS) dated 05/13/16 coded him with moderately impaired cognition, and requiring limited assistance with bed mobility, transfers, and walking.</p> <p>Review of the Care Area Assessments (CAA) revealed that the information was provided via a checklist and narrative that repeated the MDS information but did not analyze the information as to how the information gathered affected Resident #153 as follows:</p> <p>a. The Cognitive/Dementia CAA dated 05/17/16 noted he scored 8 out of 15 on the Brief Interview for Mental Status, had diagnoses of dementia and</p>	F 272			

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F 272	<p>Continued From page 44</p> <p>was usually understood and usually understands. The resident was noted to have behaviors including wandering, yelling, abusive language, threatening behaviors and repeated movements. The CAA listed the diagnoses of hypothyroidism and diabetes, indicated he had pain and was incontinent. The rationale for proceeding to a care plan for cognition was related to cognitive status and diagnoses.</p> <p>6. Resident #150 was admitted to the facility on 10/26/15 and diagnoses included non-Alzheimer's dementia, anxiety disorder, seizures, anemia and chronic obstructive pulmonary disease (COPD).</p> <p>The annual Minimum Data Set (MDS) dated 10/28/16 indicated Resident #150 was coded as cognitively impaired with behavior or rejection of care and received antipsychotic, antianxiety, and antidepressant medications 7 out of the last 7 days and required supervision for bed mobility, transfers, dressing, toileting, and extensive assistance of 1 person for personal hygiene.</p> <p>Review of the Care Area Assessment (CAA) dated 10/28/16 revealed the following area was not analyzed with the MDS information to determine Resident #150's strengths, weaknesses, and how his condition affected this area and no analysis of the findings explaining why this area was a problem for the resident as follows:</p> <p>Psychotropic Drug Use CAA: under nature of problem/condition was written Resident #150 received Risperdal, Busperone, and Remeron during the review period; under treatable/reversible reasons for use of</p>	F 272			

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F 272	<p>Continued From page 45</p> <p>psychotropic drug was Resident #150 had a diagnoses of anemia and COPD; under adverse consequences of antidepressants exhibited by Resident #150 was checked as anxiety and weight gain and indicated resident had a diagnoses of anxiety and epilepsy and had a weight gain of 10% in 180 days; under care plan considerations Resident #150 was checked as slow or minimize decline and avoid complications. There was no analysis to identify nature of condition for use of psychotropic, antidepressant, and antianxiety medication and the effects the medication had on Resident 150's quality of life and indicated a care plan would be created for psychotropic drug use related to current status, diagnosis, and potential influences.</p> <p>On 02/10/17 at 5:40 PM an interview was conducted with the Resident Care Management Director (RCMD) who stated she oversaw 2 MDS Coordinators and the MDS Coordinator who had completed the resident's CAA had left for the day. The RCMD stated all members of the interdisciplinary team who completed sections of the MDS were spoken with in order to complete the CAA. The RCMD stated observations of the resident were made, family members were interviewed, nurse's notes were reviewed, and medical record documentation was reviewed to compete the CAA and the information was plugged into the body of the CAA. The RCMD stated the information on the CAA would be placed directly on the care plan for the resident. She further stated that she was trained that all the information on the MDS was what was included in the CAA and the analysis was the decision to proceed to care for the reasons listed in that section. The RCMD stated all areas were checked on the CAA that pertained to the resident but the</p>	F 272			

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F 272	<p>Continued From page 46</p> <p>information was not repeated in the analysis of findings. The RCMD stated she was not aware that an individualized analysis of findings was required to be summarized for the resident.</p> <p>On 02/10/17 at 6:53 PM an interview was conducted with the Director of Nursing who stated her expectation was that the CAA would have included an individualized written summarization of the information obtained regarding the resident in order to provide appropriate care.</p> <p>7. Resident #44 was admitted to the facility on 05/06/16 and diagnoses included atrial fibrillation, hypertension, renal insufficiency, diabetes mellitus, cerebral vascular accident (CVA), chronic obstructive pulmonary disease (COPD), anxiety disorder, and depression.</p> <p>The annual Minimum Data Set (MDS) dated 11/08/16 indicated Resident #44 was coded as cognitively intact with behavior or rejection of care and received antianxiety and antidepressant medications 7 out of the last 7 days and required extensive assistance of 2 person for bed mobility, transfers, dressing, toileting, and personal hygiene.</p> <p>Review of the Care Area Assessment (CAA) dated 11/08/16 revealed the following area was not analyzed with the MDS information to determine Resident #44's strengths, weaknesses, and how her condition affected this area and no analysis of the findings explaining why this area was a problem for the resident as follows:</p> <p>Psychotropic Drug Use CAA: under nature of problem/condition was written Resident #44 received Cymbalta and Busperone during the</p>	F 272			

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F 272	<p>Continued From page 47</p> <p>review period; under treatable/reversible reasons for use of psychotropic drug was Resident #44 had a diagnoses of atrial fibrillation, hypertension, diabetes mellitus, and COPD; under adverse consequences of antidepressants exhibited by Resident #44 was checked as anxiety and indicated Resident #44 had a diagnosis of anxiety; under adverse consequences of antipsychotics exhibited by Resident #44 was checked as cardiac arrhythmias and CVA and indicated the resident had diagnoses of atrial fibrillation, depression, and cerebral infarction; under adverse consequences of anxiolytics exhibited by Resident #44 was checked as disturbances of balance, gait, positioning ability and indicated the resident required extensive assistance with transfers; under care plan considerations Resident #44 was checked as improvement, slow or minimize decline, and avoid complications. There was no analysis to identify nature of condition for use of antidepressant and antianxiety medication and the effects the medication had on Resident #44's quality of life and indicated a care plan would be created for psychotropic drug use related to current status, diagnosis, and potential influences.</p> <p>On 02/10/17 at 5:40 PM an interview was conducted with the Resident Care Management Director (RCMD) who stated she oversaw 2 MDS Coordinators and the MDS Coordinator who had completed the resident's CAA had left for the day. The RCMD stated all members of the interdisciplinary team who completed sections of the MDS were spoken with in order to complete the CAA. The RCMD stated observations of the resident were made, family members were interviewed, nurse's notes were reviewed, and medical record documentation was reviewed to</p>	F 272			

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F 272	<p>Continued From page 48</p> <p>compete the CAA and the information was plugged into the body of the CAA. The RCMD stated the information on the CAA would be placed directly on the care plan for the resident. She further stated that she was trained that all the information on the MDS was what was included in the CAA and the analysis was the decision to proceed to care for the reasons listed in that section. The RCMD stated all areas were checked on the CAA that pertained to the resident but the information was not repeated in the analysis of findings. The RCMD stated she was not aware that an individualized analysis of findings was required to be summarized for the resident.</p> <p>On 02/10/17 at 6:53 PM an interview was conducted with the Director of Nursing who stated her expectation was that the CAA would have included an individualized written summarization of the information obtained regarding the resident in order to provide appropriate care.</p> <p>8. Resident #198 was admitted to the facility on 11/04/16 and diagnoses included coronary artery disease (CAD), heart failure, atrial fibrillation, and non-Alzheimer's dementia.</p> <p>The admission Minimum Data Set (MDS) dated 11/11/16 indicated Resident #198 was coded as cognitively impaired with physical behaviors directed towards others and wandering and received antipsychotic and antianxiety medications 7 out of the last 7 days and required extensive assistance of 1 person for bed mobility, transfers, dressing, toileting, and personal hygiene.</p> <p>Review of the Care Area Assessment (CAA)</p>	F 272			

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F 272	<p>Continued From page 49</p> <p>dated 11/11/16 revealed the following area was not analyzed with the MDS information to determine Resident #198's strengths, weaknesses, and how her condition affected this area and no analysis of the findings explaining why this area was a problem for the resident as follows:</p> <p>Psychotropic Drug Use CAA: under nature of problem/condition was written Resident #198 received Lorazepam and Seroquel during the review period; under treatable/reversible reasons for use of psychotropic drug was Resident #198 had a diagnoses of atrial fibrillation and congestive heart failure; under adverse consequences of antipsychotics exhibited by Resident #198 was checked as cardiac arrhythmias and indicated Resident #198 had a diagnosis of atrial fibrillation; under adverse consequences of anxiolytics exhibited by Resident #198 was checked as disturbances of balance, gait, positioning ability and indicated the resident required assistance with transfers, walking, and toileting; under care plan considerations Resident #198 was checked as improvement, slow or minimize decline, and avoid complications. There was no analysis to identify nature of condition for use of antipsychotic and antianxiety medication and the effects the medication had on Resident #198's quality of life and indicated a care plan would be created for psychotropic drug use related to current status, diagnosis, and potential influences.</p> <p>On 02/10/17 at 5:40 PM an interview was conducted with the Resident Care Management Director (RCMD) who stated she oversaw 2 MDS Coordinators and the MDS Coordinator who had completed the resident's CAA had left for the day.</p>	F 272			

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F 272	<p>Continued From page 50</p> <p>The RCMD stated all members of the interdisciplinary team who completed sections of the MDS were spoken with in order to complete the CAA. The RCMD stated observations of the resident were made, family members were interviewed, nurse's notes were reviewed, and medical record documentation was reviewed to compete the CAA and the information was plugged into the body of the CAA. The RCMD stated the information on the CAA would be placed directly on the care plan for the resident. She further stated that she was trained that all the information on the MDS was what was included in the CAA and the analysis was the decision to proceed to care for the reasons listed in that section. The RCMD stated all areas were checked on the CAA that pertained to the resident but the information was not repeated in the analysis of findings. The RCMD stated she was not aware that an individualized analysis of findings was required to be summarized for the resident.</p> <p>On 02/10/17 at 6:53 PM an interview was conducted with the Director of Nursing who stated her expectation was that the CAA would have included an individualized written summarization of the information obtained regarding the resident in order to provide appropriate care.</p> <p>9. Resident #52 was admitted to the facility on 01/09/2009 and re-admitted on 11/19/2015. Her diagnoses included deep vein thrombosis (DVT), heart failure, peripheral vascular disease, renal insufficiency with hemodialysis 3 times weekly and right above the knee amputation.</p> <p>The significant change Minimum Data Set (MDS)</p>	F 272			

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F 272	<p>Continued From page 51</p> <p>dated 10/25/16 coded her with intact cognition and no behaviors. It was coded that she required extensive assistance with transfers, toileting, personal hygiene and bed mobility. She was coded as not walking and incontinent for occasional urine and bowel. She was on scheduled and as needed pain medication and had hemodialysis on Monday, Wednesday and Friday.</p> <p>Review of the Care Area Assessments (CAA) revealed that the information was provided via checklist and narrative that repeated the MDS information but did not analyze the information as to how the information gathered affected Resident #52 as follows:</p> <p>a. The Urinary Incontinence CAA dated 10/27/16 revealed that the triggering condition was activities of daily living (ADL) assistance for toileting was needed as indicated by resident requiring extensive assistance with toileting. The modifiable factors contributing to the incontinence were identified as psychological problems, pain and restricted mobility. Diseases and conditions contributing to the problem were diabetes, congestive heart failure and depression. The rationale for continuing to care planning for urinary incontinence was related to current status, diagnoses and potential influences.</p> <p>b. The Nutritional Status CAA dated 10/27/16 revealed the triggering conditions were body mass index (BMI) of 42.7, therapeutic diet, and skin conditions. She was coded as having poor memory and anxiety problems that interfered with her eating. She was also coded as having the following conditions that can affect appetite or nutritional needs: anemia, cardiovascular disease, depression, pain, renal disease, diabetes and recent surgical procedure. The rationale for continuing to care planning for</p>	F 272			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/08/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345221</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/10/2017</b>
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F 272	<p>Continued From page 52</p> <p>nutritional status was related current status, diagnoses and potential influences.</p> <p>Interview with the MDS Coordinator/Supervisor on 02/10/2017 at 5:40 PM revealed the MDS staff who completed this CAA had left for the day. MDS Coordinator/Supervisor stated that the CAA should check or note any and all information, facts not opinions, gathered from the MDS that may have some effect on the care area. She further stated that she was trained that all the information on the MDS was what was included in the CAA and the analysis was the decision to proceed to care for the reasons listed in that section. She stated she was unaware that there should be some analysis describing the individual resident.</p> <p>Interview with the Director of Nursing on 02/10/2017 at 6:53 PM revealed she expected the MDSs to be accurate and the CAAs to paint a picture of the resident and be individualized so the reader could follow the thought process to provide appropriate care.</p> <p>10. Resident #100 was admitted to the facility on 05/05/2016. Her diagnoses included Parkinson's disease, depression, schizophrenia, stage 3 chronic renal disease and deep vein thrombosis (DVT).</p> <p>The quarterly Minimum Data Set (MDS) dated 01/05/17 coded her with severely impaired cognition, no behaviors, mechanically altered diet, on antidepressant and anticoagulant daily. It was coded that she required extensive assistance with bed mobility, transfer, dressing, toileting and personal hygiene. She was coded as not steady with moving from seated to standing position and not steady with walking, and coded as always incontinent of bowel and bladder.</p>	F 272			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/08/2017  
FORM APPROVED  
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F 272	Continued From page 53  Review of the Care Area Assessment (CAA) revealed the information was provided via a checklist and narrative that repeated the MDS information but did not analyze the information as to how the information gathered affected Resident #100 as follows: a. The Falls CAA dated 3/17/16 noted resident had balance problems during transition and received an antidepressant daily, had difficulty maintaining a sitting balance and had impaired balance during transitions, was on antidepressants and diuretics. She was coded as having cognitive impairment, anxiety disorder, depression, incontinence, Parkinson's disease and visual impairment. The rationale for proceeding to care planning for falls was related to current status, diagnoses and potential influences. Interview with the MDS Coordinator/Supervisor on 02/10/17 at 5:40 PM revealed the MDS staff who completed this CAA had left for the day. MDS Coordinator/Supervisor stated that the CAA should check or note any and all information, facts not opinions, gathered from the MDS that may have some effect on the care area. She further stated that she was trained that all the information on the MDS was what was included in the CAA and the analysis was the decision to proceed to care for the reasons listed in that section. She stated she was unaware that there should be some analysis describing the individual resident. Interview with the Director of Nursing on 02/10/2017 at 6:53 PM revealed she expected the MDSs to be accurate and the CAAs to paint a picture of the resident and be individualized so the reader could follow the thought process to provide appropriate care.	F 272			

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F 272	Continued From page 54  11. Resident #56 was admitted to the facility on 01/17/17. Her diagnoses included renal insufficiency, arthritis, anxiety disorder, depression and respiratory failure with dependency on oxygen. The admission Minimum Data Set (MDS) dated 01/24/17 coded her with intact cognition and no behaviors, adequate vision with glasses, and feeling down, depressed or hopeless 1 day. It was coded that she required extensive assistance with bed mobility, transfers, dressing, toileting and personal hygiene, occasionally incontinent of bladder and frequently incontinent of bowel. She was coded as receiving physical therapy, occupational therapy and speech therapy and receiving antianxiety medications 4 days, antidepressant medication 7 days, diuretic medication 7 days and oxygen therapy 7 days. Review of the Care Area Assessment (CAA) revealed the information was provided via a checklist and narrative that repeated the MDS information but did not analyze the information as to how the information gathered affected Resident #100 as follows: a. The Pain CAA dated 01/27/17 noted Resident #56 had chronic pain related to arthritis, spinal stenosis and osteoporosis, had sleep disturbance and adversely affected mood due to her pain. The rationale for proceeding to care planning for pain was related to current status, diagnoses and potential influences. Interview with the MDS Coordinator/Supervisor on 02/10/17 at 5:40 PM revealed the MDS staff who completed this CAA had left for the day. MDS Coordinator/Supervisor stated that the CAA should check or note any and all information, facts not opinions, gathered from the MDS that may have some effect on the care area. She	F 272			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/08/2017  
FORM APPROVED  
OMB NO. 0938-0391

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F 272	<p>Continued From page 55</p> <p>further stated that she was trained that all the information on the MDS was what was included in the CAA and the analysis was the decision to proceed to care for the reasons listed in that section. She stated she was unaware that there should be some analysis describing the individual resident.</p> <p>Interview with the Director of Nursing on 02/10/2017 at 6:53 PM revealed she expected the MDSs to be accurate and the CAAs to paint a picture of the resident and be individualized so the reader could follow the thought process to provide appropriate care.</p> <p>12. Resident #58 was admitted to the facility on 05/25/16. His diagnoses included Alzheimer's disease, dementia with Lewy bodies, anxiety disorder, depression, paranoid, delusional and osteoarthritis.</p> <p>The quarterly Minimum Data Set (MDS) dated 01/10/17 coded him with severely impaired cognition, no behaviors, wears glasses and hearing aide, totally dependent for bathing and requires supervision and set up for most other ADL, received antidepressant, and diuretic for 7 days. He was coded as being occasionally incontinent of urine and always continent of bowel.</p> <p>Review of the Care Area Assessment (CAA) revealed the information was provided via a checklist and narrative that repeated the MDS information but did not analyze the information as to how the information gathered affected Resident #58 as follows:</p> <p>a. The Psychotropic Drug Use CAA dated 6/3/16 noted Resident #58 had antidepressant medication Lexapro administered to him since admission, had atrial fibrillation, hypertension,</p>	F 272			

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F 272	<p>Continued From page 56</p> <p>orthostatic hypotension and coronary artery disease, had anxiety and increased risk for falls. The rationale for proceeding to care planning for psychotropic drug use was related to current status, diagnoses and potential influences. Interview with the MDS Coordinator/Supervisor on 02/10/17 at 5:40 PM revealed the MDS staff who completed this CAA had left for the day. MDS Coordinator/Supervisor stated that the CAA should check or note any and all information, facts not opinions, gathered from the MDS that may have some effect on the care area. She further stated that she was trained that all the information on the MDS was what was included in the CAA and the analysis was the decision to proceed to care for the reasons listed in that section. She stated she was unaware that there should be some analysis describing the individual resident.</p> <p>Interview with the Director of Nursing on 02/10/2017 at 6:53 PM revealed she expected the MDSs to be accurate and the CAAs to paint a picture of the resident and be individualized so the reader could follow the thought process to provide appropriate care.</p> <p>13. Resident #54 was re-admitted to the facility on 10/19/14 with diagnoses which included congestive heart failure, chronic heart disease, chronic respiratory failure, type 2 diabetes, generalized muscle weakness, a lack of coordination and macular degeneration (a deterioration in the eye causing distortion or vision loss in the center of the eye).</p> <p>A review of the annual Minimum Data Set (MDS) dated 07/18/16 indicated Resident #54 was cognitively intact for daily decision making and</p>	F 272			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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F 272	Continued From page 57 required supervision with activities of daily living (ADLs) except for limited assistance with hygiene.  A review of the Care Area Assessments (CAA) revealed that the information was provided via a checklist and narrative that repeated the MDS information but did not analyze the information as to how the information gathered affected Resident #54 as follows: The Delirium CAA dated 07/18/16 noted Resident #54 was alert and oriented, could make some decisions and made her needs known and see BIMS assessment by the Social Worker for more information. The CAA further indicated Resident #54 had mild cognitive impairment diagnosis and was at risk for decline.  Interview with the MDS Coordinator/Supervisor on 02/10/17 at 5:40 PM revealed the MDS staff who completed this CAA had left for the day. MDS Coordinator/Supervisor stated that the CAA should check or note any and all information, facts not opinions, gathered from the MDS that may have some effect on the care area. She further stated that she was trained that all the information on the MDS was what was included in the CAA and the analysis was the decision to proceed to care for the reasons listed in that section. She stated she was unaware that there should be some analysis describing the individual resident.  Interview with the Director of Nursing on 02/10/2017 at 6:53 PM revealed she expected the MDSs to be accurate and the CAAs to paint a picture of the resident and be individualized so the reader could follow the thought process to provide appropriate care.	F 272			
F 278	483.20(g)-(j) ASSESSMENT	F 278		3/10/17	

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F 278 SS=D	Continued From page 58 <b>ACCURACY/COORDINATION/CERTIFIED</b>  (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.  (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  (i) Certification (1) A registered nurse must sign and certify that the assessment is completed.  (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.  (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly-  (i) 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  (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment.  (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to code the Minimum	F 278	Corrective action was accomplished for the alleged deficient practice for Resident		

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F 278	<p>Continued From page 59</p> <p>Data Set (MDS) assessment accurately to reflect broken bottom teeth for 1 of 4 sampled residents reviewed for dental status and dental services (Resident #52).</p> <p>The findings included:</p> <p>Resident #52 was admitted on 01/09/2009 and re-admitted on 11/19/2016 with diagnoses that included end stage renal disease and renal insufficiency with hemodialysis 3 times weekly, deep vein thrombosis, heart failure, anxiety disorder and diabetes mellitus.</p> <p>Review of the medical record revealed Resident #52 was examined by the Dentist on 01/20/16. The Dentist noted Resident #52 required hospital extraction of her remaining broken lower teeth. The dental form was signed by the resident. On 2/17/16 there was an order written by the doctor that Resident #52 was okay for dental extraction.</p> <p>Review of the significant change Minimum Data Set (MDS) dated 10/25/2016 revealed Resident #52 was cognitively intact. Under the section for Oral and Dental Status, Resident #52 was coded as having no dental problems. The option for "Obvious or likely cavity or broken natural teeth" was not checked on the significant change MDS.</p> <p>During an interview on 02/07/2017 at 10:21 AM Resident #52 stated she had been trying some time to schedule an appointment to get her bottom 6 broken teeth pulled so she could be fitted for a denture. Resident #52 stated that it had been scheduled but her lab work was out of range and she was unable to have the surgery. She stated she had to have two different surgeries in 2016 and was just now feeling up to</p>	F 278	<p>#52 . A significant correction to prior comprehensive assessment MDS with ARD 2/11/17 was completed by the RCMD or MDS Coordinator on 2/23/17 to accurately reflect the residents dental status.</p> <p>All Residents have the potential to be affected by this alleged deficient practice. An audit of current residents receiving a comprehensive MDS completed during the last 14 days was completed by the Resident Care Management Director to verify accurate assessment of those residents dental status on 2/23/17. No additional residents were identified by the audit. Prior to the audit the MDS Coordinator identified resident MR number 2015589 required correction due to a coding error. A significant correction was completed by the MDS Coordinator with an ARD date of 2/17/17 per RAI manual guidelines.</p> <p>The Resident Care Management Director (RCMD) re-educated the Interdisciplinary team and MDS staff on accurate MDS coding related to dental status on 2/14/17 and 2/22/17. The RCMD will randomly review 5 completed MDSs weekly for 12 weeks to verify accurate coding of dental status. Opportunities will be corrected as identified as a result of these audits.</p> <p>The results of these audits will be presented by the Resident Care Management Director monthly for 3 months at Facility QAPI meeting. The committee will make changes or</p>		

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F 278	<p>Continued From page 60</p> <p>having the extraction done. Resident #52 stated that the Dentist had told her that she would have to go to the hospital to be put to sleep to have the extraction. She stated that she would have to see the Dentist again in March to get referred for the extraction.</p> <p>During an interview on 02/10/2017 at 1:34 PM with the nurse who completed Resident #52 initial nursing assessment it was revealed that the nurse knew that the resident had her own bottom teeth that were broken. The nurse stated that she should have marked on the initial assessment that the resident had bottom teeth that were broken.</p> <p>During an interview on 02/10/2017 at 2:17 PM with the Director of Nursing (DON) she stated that she would expect the nurse completing the resident assessment to mark that the resident had bottom teeth that were broken.</p> <p>An interview with the Resident Care Management Director on 02/10/2016 at 5:40 PM who oversees two MDS coordinators revealed that the coordinators get their information for the MDS from several sources. Director stated that the MDS coordinators are not responsible for sections C, D and Q they are done by the social worker; however the coordinators are still responsible for the CAA for those sections. She stated that section F is done by activities and L is done by the nurses but the coordinators are still responsible for the CAAs for these sections as well. The Director stated that their process consists of a comprehensive review of a lot of data including hospital records, discharge summary, Medicine Administration Record (MAR), Treatment Administration Record (TAR),</p>	F 278	recommendations as indicated.		

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F 278	Continued From page 61 history and physical document, physician and nursing progress notes, therapy notes, social work and dietary notes, incident/accident reports, resident observations and resident and family interviews. She stated the collected data is then entered into the MDS and this information triggers the CAAs. The Director stated that the triggered CAAs are then utilized to develop a 72 hour care plan for the resident. The Director stated that she should have marked Resident #52 as having broken teeth.  An interview with the DON on 02/10/2016 @ 6:01 PM revealed that she expected the MDS coordinators to code Resident #52 as having broken teeth.	F 278			
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS  (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review, family interview, and staff interview, the facility failed to provide incontinent care for 1 of 1 resident who was observed to be visibly soiled when his meal tray was served (Resident #114).  The findings included:  Resident #114 was admitted to the facility on 03/03/16. His diagnoses included dementia, restlessness and agitation, muscle weakness, and chronic pain syndrome.	F 312	Criteria 1 • On 2/9/17 the Nurse Aide and Charge Nurse provided incontinent care for Resident #114 following completion of the breakfast meal. Criteria 2 • Current residents requiring assistance with incontinent care have the potential to be affected by this alleged deficient practice. On 2/27/17 the Nurse Managers conducted an audit of residents requiring assistance with incontinent care and validated completion prior to initiating	3/10/17	

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F 312	<p>Continued From page 62</p> <p>The annual Minimum Data Set dated 01/19/17 coded him with severely impaired cognition, verbal behaviors 1 to 3 times in previous 7 days, rejection of care 4 to 6 times in the previous 7 days, and having worse behaviors since the previous assessment. It was coded that he required extensive assistance with transfers, toileting and hygiene. He was also coded as being always incontinent of bowel and bladder.</p> <p>The Care Area Assessment dated 01/25/17 related to urinary incontinence stated Resident #114 required assistance with transfers, dressing and toileting.</p> <p>Review of the care plan for bladder incontinence related to dementia last revised on 01/28/17 included the goal to have decreased frequency of urinary incontinence and prevent infections. The interventions included to check every 2 hours and as required for incontinence. Wash rinse and dry perineum. Change clothing as needed after incontinence episodes and toilet every 2 hours while awake.</p> <p>On 02/09/17 at 9:16 AM, family reported to the surveyor that Resident #114 was visibly wet in the front of his gown that morning and all staff did was change his gown and give him a clean blanket for his lap but that no one changed him for breakfast. He was sitting in a gerichair across from the nursing station at that time.</p> <p>On 02/09/17 at 9:34 AM, Nurse Aides (NA) #1 and #2 assisted Resident #114 to the shower room and proceeded to assist him to the commode. Resident #114 stood and the blanket upon which he sat was soaked with urine and his pants and brief were soaked with urine. When</p>	F 312	<p>meal service.</p> <p>Criteria 3</p> <ul style="list-style-type: none"> <li>Nursing Staff were re-educated by 3/10/17 by the Administrator, DON &amp; Nurse Managers on the expectation of providing residents with assistance of completion of ADLs with a focus surrounding preparing residents for mealtime.</li> <li>The Nurse Managers will randomly observe 10 residents per week, who require assistance with incontinent care for 12 weeks, to validate completion of ADL assistance including incontinent care prior to initiation of meal service. Opportunities will be corrected as identified during these audits.</li> </ul> <p>Criteria 4</p> <ul style="list-style-type: none"> <li>To assure continued compliance with these processes the Unit Manager will present audit results at the monthly QAPI meeting x three months. The QAPI Committee will make any recommended necessary changes.</li> </ul>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 312	<p>Continued From page 63</p> <p>the NAs were asked about the last time he was checked and toileted, they responded that they had not checked or toileted him since coming on at 7:00 AM.</p> <p>On 02/09/17 at 10:11 AM Nurse #1 stated during interview that as staff were passing the breakfast trays, she noticed that Resident #114's gown was wet. She stated that she could not provide the care herself so she wanted to make him as comfortable as possible so she changed his gown and blanket and then he received his breakfast tray.</p> <p>Upon follow up interview on 02/10/17 at 1:30 PM, Nurse #1 stated Resident #114's gown had been wet about 6 inches in diameter around the left front of his stomach. She stated she assumed it was urine. She stated he required 2 persons to transfer and staff were passing trays so she decided to try and make him as comfortable as she could. Resident #114 was known to urinate excessively due to his diuretic use and refused care at times.</p> <p>A follow up interview with NA #1 on 02/10/17 at 1:38 PM revealed that when she and NA #2 arrived at 7 AM on 02/09/17, they offered to get him dressed. He stated no. NA #1 further stated he was more cooperative with family around.</p> <p>Interview with the Director of Nursing on 02/10/17 at 3:00 PM revealed she expected staff to check residents for incontinence prior to meal services. She further stated that if a resident was visibly wet at the meal, she would want that resident changed and not sitting and eating soiled.</p>	F 312			
F 367	483.60(e)(1)(2) THERAPEUTIC DIET	F 367		3/10/17	

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F 367 SS=D	Continued From page 64 PRESCRIBED BY PHYSICIAN  (e) Therapeutic Diets  (e)(1) Therapeutic diets must be prescribed by the attending physician.  (e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on medical record review, observations and staff interviews the facility failed to serve 1 of 1 resident on a 2 gram sodium diet food consistent with low sodium restrictions. (Resident #155)  The findings included:  Resident #155 was admitted to the facility 01/20/17 with diagnoses which included chronic kidney disease, hypertension and left ventricular failure. Medications ordered by the physician and taken routinely by Resident #155 included Diltiazem (a medication to treat high blood pressure, angina and heart rhythm disorder), Metoprolol (a medication to treat high blood pressure, angina and heart failure) and Lasix (a diuretic). Physician orders, on admission, included a puree, 2 gram sodium diet order.  The admission Minimum Data Set (MDS) for Resident #155 noted severe cognitive impairment, required supervision with set-up help and was on a mechanically altered/therapeutic diet. The nutrition Care Area Assessment	F 367	Corrective action was taken for resident #155 immediately on 2/10/17 by the Dietary Manager. The diet was corrected to include 2gm sodium restriction with a mechanical soft diet on tray ticket to match physicians order.  A facility wide audit was conducted by the Dietary Manager on 2/13/17 with assistance from the DON and the Registered Dietician. Meal Tracker is the system dietary uses to print meal tickets. Diet orders are entered into meal tracker by dietary manager upon receiving a diet requisition form from nursing/therapy. Point click care (PCC) is the user system where physicians orders, including therapy orders are input. All diets on PCC were compared to diets in Meal tracker to determine if other residents were affected by the alleged deficient practice. Although, there were no other residents affected by the alleged deficient practice, there were three resident's diet orders that needed to be clarified. Resident with		

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F 367	Continued From page 65 associated with the MDS review noted Resident #155 was on a 2 gram sodium diet.  The current care plan for Resident #155 included the following problem areas: -Resident #155 has an activity of daily living self-care performance deficit related to cognitive impairment, weakness. Approaches to this problem area included, the resident is able to self feed after set-up. -Resident #155 has congestive heart failure. Approaches to this problem area included, encourage adequate nutrition. -Resident #155 has hypertension. Approaches to this problem area included, educate the resident/family/caregiver about: the importance of maintaining a normal weight for height, the value of regular exercise, limiting salt intake and the importance of medication and diet compliance. -Resident #155 has altered cardiovascular status related to congestive heart failure, hypertension and left ventricular heart failure. Approaches to this problem area included, encourage low fat, low salt intake. -Resident #155 has potential for nutritional problem related to diagnosis dementia, congestive heart disease, chronic kidney disease and advanced age. Approaches to this problem area included provide, serve diet as ordered. -Resident #155 has renal insufficiency. Approaches to this problem area included, resident/family/caregiver teaching to include the importance of compliance with dietary restrictions. -The resident currently receiving rehab therapy from the services of physical therapy, occupational therapy, speech therapy. Approaches to this problem area included,	F 367	medical record number 2015594 was admitted on a cardiac, chopped meats, low saturated fat diet, NAS. The DON clarified this diet to low fat/low cholesterol NAS mechanical soft on 2/13/17. Resident with medical record number 2015307 was admitted on cardiac low saturated fat NAS diet. The Registered Dietician clarified this diet to low fat/low cholesterol, NAS on 2/14/17. Resident with medical record number 2015592 was admitted on a CCD/NAS low saturated fat diet. The Registered Dietician clarified this diet to a CCD/NAS low fat/low cholesterol diet on 2/14/17.  TO prevent the alleged deficient practice from occurring again, the Dietary Manager has asked that all Diet Requisition forms filled out by the therapy department include the flagged message "Therapy" at the top. All staff were educated on the alleged deficient practice on 2/15/17. The Dietary Manager will also compare all Diet Requisition forms with PCC before making any changes on Mealtracker.  The measure have been put in place to assure the alleged deficient practice does not reoccur. The dietary manager will complete weekly audits to assure that physician's orders in PCC match the diet orders in meal tracker to include a weekly audit for 6 weeks starting on 2/13/17 and ending on 3/20/17 to follow by monthly audits for 6 months starting on 4/3/17 and ending on 10/3/17.  The Dietary Manager will present results		

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F 367	<p>Continued From page 66</p> <p>provide therapy per orders-monitor progress.</p> <p>Review of speech therapy progress notes and discharge recommendations on 01/30/17 included diet modifications of mechanical soft texture. In an interview on 02/10/17 at 8:55 AM the speech therapist stated after discharge from treatment on 01/30/17 recommendations were written for the diet of Resident #155 to be upgraded from puree to mechanical soft. The speech therapist stated she did not make recommendations on any therapeutic restrictions and, 2 gram sodium restrictions should have been included with the mechanical soft restrictions. A physician's order on 01/30/17 included, 2 gram sodium, mechanical soft diet.</p> <p>A progress note written by the Registered Dietitian on 01/26/17 included: Resident #155 has orders for a diuretic, is on a 2 gram sodium diet and eats 51-100% of his meals. Continue current plan of care, "remains appropriate."</p> <p>Observations of meals served to Resident #155 included the following: -On 02/07/17 at 5:30 PM Resident #155 was observed eating his supper meal in his room. The food served to Resident #155 included 2 grilled cheese sandwiches. Review of the preplanned menu for a 2 gram sodium diet noted a turkey sandwich should have been served, not grilled cheese. -On 02/09/17 at 8:20 AM Resident #155 was observed eating his breakfast meal in his room. The food served to Resident #155 included ground sausage and cream gravy. Review of the preplanned menu for a 2 gram sodium diet noted sausage and cream gravy should not be served. -On 02/09/17 at 1:12 PM Resident #155 was</p>	F 367	<p>of the audits at QAPI each month. The QAPI Committee will recommend any changes if needed</p>		

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F 367	<p>Continued From page 67</p> <p>observed eating lunch in his room. The food served to Resident #155 included red beans and sausage. In addition, a salt packet had been served which was open and had been put on the food of Resident #155. Review of the preplanned menu for a 2 gram sodium diet noted a beef patty and rice should have been served, not red beans and sausage.</p> <p>-On 02/10/17 at 8:00 AM Resident #155 was observed eating breakfast in the dining room. The food served to Resident #155 included ground sausage and cream gravy. Review of the preplanned menu for a 2 gram sodium diet noted sausage and cream gravy should not be served.</p> <p>On 02/10/17 at 11:55 AM the food service district manager and food service director reviewed the physician's diet order as well as what was in the electronic tray card system for Resident #155. The food service district manager and food service director noted physician orders in the medical record of Resident #155 included 2 gram sodium restrictions. The food service district manager and food service director stated when the speech therapist sent the recommendations for the diet of Resident #155 to be changed on 01/30/17 from puree to mechanical soft the 2 gram sodium restrictions had been discontinued in the electronic tray card system. The food service district manager stated because the diet order in the electronic tray card system was mechanical soft foods, the 2 grams sodium restrictions had not been followed. The food service district manager stated when the mechanical soft modifications had been made by the speech therapist the therapeutic 2 gram sodium restrictions should have been clarified and continued.</p>	F 367			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 367	Continued From page 68 On 02/10/17 at 3:44 PM the Administrator and Director of Nursing stated they expected food to be served consistent with the physician's order which would have included the 2 gram sodium restrictions for Resident #155.	F 367			
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.  (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.  (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--  (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and  (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 431		3/10/17	

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F 431	<p>Continued From page 69</p> <p>appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>(h) Storage of Drugs and Biologicals.</p> <p>(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations and staff interviews the facility failed to discard an opened box of expired medication and an opened bottle of expired medication from 2 of 4 medication carts, (the 600 Hall cart and the 100 Hall cart.)</p> <p>1. Observation of the medication cart for the 600 hall on 02/10/2017 at 11:17 AM revealed an open bottle of Nitrostat 0.3 milligram (mg) tablets and there were 97 pills in the bottle. The pharmacy label stated the medication was prescribed for Resident #21 and had an expiration date of 12/2016. The expiration date was imprinted on the manufacturer label as well as on the pharmacy label.</p> <p>Nurse # 1 was interviewed when the bottle of</p>	F 431	<p>Criteria 1</p> <p>" Nitro-Stat &amp; Nicoderm CQ were immediately removed from the medication cart on 2/10/17 by the Unit Manager.</p> <p>Criteria 2</p> <p>" All residents have the potential to be affected by this alleged deficient practice. An audit was conducted on all medication carts, medication rooms and medication storage areas by the Medication Aides and Charge Nurses by 2/24/17. Any expired or undated medications identified during this audit were discarded immediately on 2/24/17.</p>		

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F 431	<p>Continued From page 70</p> <p>expired medication was discovered on 02/10/2017 at 11:17 AM and stated that the night nurses check the carts weekly for expired meds and the nurse consultant had checked the medication cart earlier in the week. She stated that the expired bottle of medication should have been removed from the cart when it expired 12/2016. Nurse #1 discarded the bottle of expired medication and ordered a new one for the resident.</p> <p>An interview with the Director of Nursing (DON) on 02/10/2017 at 11:43 AM revealed that the night shift nurses were responsible for checking the medication rooms and medication carts weekly for expired medications and she would have expected the bottle of Nitrostat to have been removed from the medication cart when it expired 12/2016.</p> <p>2. Observation of the medication cart for the 100 hall on 02/10/2017 at 10:36 AM revealed an opened box of NicoDerm clear patch extended release 24 hours which contained 11 patches. The pharmacy label stated the medication was prescribed for Resident #214 and an expiration date of 01/2017. The expiration date was imprinted on the manufacturer label as well as on the pharmacy label.</p> <p>Nurse #4 was interviewed as she was about to take the expired patch and apply to the resident. She confirmed the box of NicoDerm patches was expired and should have been removed from the cart. She stated that the night nurses check the carts weekly for expired meds and should have removed the box of expired patches from the medication cart when it expired 01/2017. Nurse #4 discarded the expired patches and ordered a</p>	F 431	<p>Criteria 3</p> <p>" The Administrator, DON &amp; Nurse Managers re-educated Licensed Nurses and Certified Medication Aides on the facility policy for dating, labeling, storing and monitoring medications by 3/10/17.</p> <p>Each med aide is assigned two med carts that are not their own, to inspect and remove medications prior to expiration each week. This schedule assures that each med card is inspected each week.</p> <p>" The Nurse Managers will randomly monitor medication carts and medication storage areas 3 times per week for 12 weeks to validate stored medications for dating, labeling and expiration. Any opportunities identified as result of these audits will be corrected immediately.</p> <p>Criteria 4</p> <p>" To assure continued compliance with these processes the DON will present the audit results to the QAPI Committee at the monthly meeting x three months. The QAPI Committee will make recommendations for any changes necessary.</p>		

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F 431	Continued From page 71 new box for the resident.  An interview with the Director of Nursing (DON) on 02/10/2017 at 11:43 AM revealed that the night shift nurses were responsible for checking the medication rooms and medication carts weekly for expired medications and she would have expected the box of NicoDerm patches to have been removed from the medication cart when they expired 1/2017.	F 431			
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS  (g) Quality assessment and assurance.  (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:  (i) The director of nursing services;  (ii) The Medical Director or his/her designee;  (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and  (g)(2) The quality assessment and assurance committee must :  (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and	F 520		3/10/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345221</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/10/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRIAN CENTER H &amp; REHAB WEAVERV</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>78 WEAVER BOULEVARD</b> <b>WEAVERVILLE, NC 28787</b>		
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F 520	<p>Continued From page 72</p> <p>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;</p> <p>(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, and staff interviews the facilities Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor their interventions that the committee put into place in March of 2016. This was for one recited deficiency which was originally cited in March of 2016 and on the current recertification survey. The deficiency was in the area of Minimum Data Set (MDS) accuracy. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program.</p> <p>Findings included:</p> <p>This tag is cross referred to:</p> <p>1. F 278 Minimum Data Set (MDS) Accuracy/Coordination/Certification: Based on observations, record reviews, resident and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately to reflect</p>	F 520	<p>Corrective action has been taken for the alleged deficient QAPI practice by implementing the above POC for F278 identified in the survey. A significant correction was completed for resident 52 on 2/23/17 by the RCMD.</p> <p>All residents have the potential to be affected by the same deficient practice. Audits were conducted by the RCMD on 2/23/17 for the current residents receiving a comprehensive MDS assessment during the last 14 days with no additional coding errors identified. Prior to the audit the MDS Coordinator identified one additional coding error for resident MR# 2015589 which was corrected by the RCMD with a ARD of 2/17/17.</p> <p>To prevent the alleged deficient practice from reoccurring, the RCMD in-serviced all MDS staff on 2/14/17 and 2/22/17 regarding the importance of accurate MDS coding and a review of the RAI guidelines. The RCMD or designee will</p>		

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F 520	<p>Continued From page 73</p> <p>bottom broken teeth for 1 out of 4 sampled residents reviewed for dental status and dental services (Resident #52). The facility was recited for F 278 for MDS failure to code broken bottom teeth on a resident. F 278 MDS Accuracy/Coordination/Certification was originally cited during the March 3, 2016 recertification survey for MDS failure to code a Level II Preadmission Screening and Resident Review (PASRR) determination for a resident, hospice care for a resident and corrective lenses for a resident with impaired vision wearing glasses.</p> <p>An interview with the Administrator on 02/10/2017 at 6:50 PM revealed that the facility has a Quality Assurance and Assessment process in place that meets on a monthly basis. These meetings consist of the Administrator, Medical Director, Director of Nursing (DON) and all the department heads. On a quarterly basis they have a Quality Assurance and Process Improvement (QAPI) meeting that consists of the monthly members, all the physicians, nurse practitioners and the pharmacist. The Administrator stated they typically look at all citations and monitor those at least 90 days after surveys or until they achieve compliance. Additionally, they track reports such as the CASPER to compare themselves to state and federal trends. She stated they look at any trends or negative outcomes and decide if they need to develop a Process Improvement Plan (PIP). They also look at issues brought forth by the physicians, nurse practitioners or pharmacist at the QAPI meeting. The Administrator also stated they look at concern forms, accident/incident reports and if they see trends may hold an ad hoc meeting. Ones the Administrator shared they recently worked on was</p>	F 520	<p>audit 5 completed MDS weekly for 12 weeks to verify accurate coding. If additional coding errors are identified, the DDCM (District Director of Care Management) will provide additional in-servicing for MDS. Once in compliance, the RCMD will continue to audit 1 complete MDS assessment per week for 4 weeks. If no additional issues are identified, the RCMD will then audit 2 completed MDS each month on an ongoing basis.</p> <p>A monthly summary of the audit results will be presented at QAPI monthly. The committee will recommend changes to the POC if necessary.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 520	Continued From page 74 care plans and falls. She stated they discovered the MDS Coordinators were being left out of decisions made by therapy to dietary for residents to have adaptive equipment. This was resulting in the care plan not addressing the adaptive equipment so now all orders come to the morning meetings and the MDS Coordinators get a copy of all orders. The Administrator stated they look at overall systems and determine if something is broken and then develop a plan to fix the system. She stated they would be continuing to audit the MDS accuracy until they achieve compliance.	F 520			