STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345235	A. BUILDING _____ B. WING _____	02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN LAKES COMMUNITY	3801 WADE COBLE DRIVE BURLINGTON, NC 27215

(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 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on policy and record review, family, physician and staff interviews, the facility failed to implement their abuse policies and procedures in the areas of reporting, protection and investigation for 1 of 1 sampled residents (Resident #36) who had a bruise of unknown origin to the bridge of the nose, inner canthus to inner canthus and a reddened area under the right eye. Findings include: A review of the facility policy titled "Abuse, Neglect, Mistreatment and Misappropriation of Resident Property" dated 11/10/2017, read in part: It is the policy of Twin Lakes Community to encourage and support all residents, staff, families, visitors, volunteers and resident representatives in reporting any suspected acts of abuse, neglect, exploitation, involuntary seclusion or misappropriation of resident property.	F 607	The resident affected: An internal investigation regarding resident number 36 was completed by the social worker on February 27, 2018 and reviewed by the administrator. Resident, charge nurse, Assistant Director of Nursing and direct caregivers were all interviewed regarding potential resident abuse. The Residents Physician and Family were notified. The Social Worker, abuse officer, provided education on the facilities abuse policies and procedures regarding reporting, protection and investigation to all the individuals included in this investigation on February 27, 2018. The abuse policies were reviewed by administrative staff (Administrator, Social Worker, Director of Nursing and Administrative Nurses). This training was completed in the quality Measure meeting on Tuesday February 27, 2018. The Human Resource Officer is meeting with the Administrative team on March 27, 2018 to review abuse policies	3/23/18

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

Electronically Signed | 03/18/2018

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F 607	Continued From page 1 Reporting and Response: It is the policy of this facility that "abuse" allegations are reported per Federal and State Law. Procedure: Employees must always report any "abuse" or suspicion of "abuse" immediately to the Administrator. The Administrator will involve key leadership personnel as necessary to assist with reporting, investigation and follow up. The Administrator will report to the Medical Director. Investigation of injuries of Unknown Origin or Suspicious injuries: Injuries of unknown origin or suspicious injuries must be immediately investigated to rule out abuse: Injuries include, but are not limited to, bruising of the inner thigh, chest, face, and breast, bruises of an unusual size, multiple unexplained bruises, and/ or bruising in an area not typically vulnerable to trauma. Resident #36 was admitted on 12/10/17. Resident #36 has a diagnosis that included Non-Alzheimer's dementia, anemia, and seizure disorder. Review of the admission Minimum Data Set (MDS) dated 12/22/17 revealed that Resident #36 requires limited assistance for bed mobility, extensive assistance for transfers, total assistance with eating and total dependence with toileting. Resident #36 utilizes a wheelchair for ambulation and has no impairment indicated to upper and lower extremities. Resident #36 has a BIMS of 0 with short and long term memory problems. The MDS further revealed that Resident #36 has moderate cognitive impairment with poor decision making, and requires cues and supervision.	F 607	for a second time and audit for understanding. Also, copies of all the facility abuse policies were placed at each nursing station for employee review on February 27. Residents potentially affected: An audit of all residents was completed during the week of March 5, 2017. This included a head to toe skin check by a licensed nurse of all residents to identify bruising or potential abuse. No other areas of concern were identified during this audit. These audits were reviewed by the Quality Assurance Nurse for any area of concern. The abuse/investigation policies were reviewed by administrative staff (Administrator, Social Worker, Director of Nursing and Administrative Nurses). This training was completed in the quality Measure meeting on Tuesday February 27, 2018. The Human Resource Officer is meeting with the Administrative team on March 27, 2018 to review abuse policies for a second time and audit for understanding. A Training Blitz is scheduled for April 3, 4 and 5 for all staff (Nursing, dietary, Environmental Services, Activities). This training will include an abuse/investigation policy and procedure review. The facility has fully developed policies and procedures that address preventing abuse, neglect, and exploitation of residents and misappropriation of resident property. These procedures also address and define guidelines for protection, reporting and investigating. We will retrain all staff on these abuse policies and	

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F 607	Continued From page 2 Review of care plan dated 12/13/17 revealed a problem/ onset of the resident receiving aspirin and is at risk for abnormal bleeding, bruising and hematomas. The goal indicates that the resident will be free from abnormal bleeding/ bruising. The interventions included administer medications as ordered, report accidents/ injuries to MD immediately and monitor for increased bruising/ bleeding/ swelling. Review of care plan dated 12/13/17 revealed a problem/ onset of the resident being at risk for falls related to history of falls, unsteady gait, impaired mobility and impaired cognition. The goal indicates that the resident will be free of falls. The interventions included keep call light within reach, complete falls risk assessment, encourage participation in PT and OT. Review of February 2018 Incident Log revealed on 2/15/18 that Resident #36 had a hematoma, source unknown. Review of progress note dated 2/15/18 revealed that Resident #36 was noted to have a green bruise to bridge of nose of unknown origin. Resident #36 responsible party and MD notified. Will continue to monitor and inquire as reason. An observation made by surveyor on 02/19/18 at 12:53 PM revealed a 1 x 1.5 inch bruised area noted to bridge of nose, inner canthus to inner canthus and a reddened area under the right eye of Resident #36. An interview was conducted on 02/21/18 at 2:59 PM with nurse #1. The nurse revealed that the bruise to Resident #36 was of unknown origin. She telephoned Resident #36 family and made	F 607	reporting requirements. We will also educate staff on the requirements regarding reporting and investigation of injuries of Unknown Origin or Suspicious injuries. Injuries of unknown origin or suspicious injuries must be immediately investigated to rule out abuse. This training will be led by the facility Social Worker. Systemic changes: An administrative nurse will review all nursing notes daily to ensure all possible incidents have been reported. Each day the administrative nurse will complete an audit sheet to document the task was completed. This daily audit was implemented on March 19, 2018 The Director of Nursing or Designee will audit/monitor these sheets each Friday in order to ensure compliance. This weekly audit started on March 23, 2018. Starting the Week of March 5th, 2018, a head to toe skin audit is completed of all residents on a weekly basis. This included a head to toe skin check by a licensed nurse of all residents to identify bruising or potential abuse. The skin checks coordinate with the resident's bath days. Nursing staff are expected to follow facility policies regarding abuse reporting regarding any area of concern noted. The quality measure Nurse is responsible for reviewing the audits weekly and monitoring for compliance. Each employee will be issued an	

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F 607	Continued From page 3 the Medical Director (MD) aware of the bruise. An incident report was completed. Nurse #1 indicated that she did not notify the Director of Nursing (DON) or the Administrator of the bruise to Resident #36. A telephone interview was conducted on 02/22/18 at 10:35 AM with family. Family stated that the nurse verbalized that she would telephone her once the facility figured out what happened. Family indicated that no return call has been made. Family indicated they were still unaware of what the result of the facility investigation concluded. An interview was conducted on 02/22/18 at 11:17 AM with the DON. The DON revealed that she was notified about bruise on resident on 02/21/2019. She expects to be notified of any bruises along with family notification and md notification. The DON revealed that a nursing note should have been completed, as well as, an incident report. The DON reiterated that her expectation of staff when they have a bruise of unknown origin was to report to the DON and Administrator. The Social Worker (SW) would have also been notified to assist in the investigation. No investigation, 24 hour or 5 day working report was completed. An interview with the Administrator on 02/22/18 at 02:21 PM revealed that her expectation of a bruise of unknown origin needs to be reported to the State Agency. If there are any suspicions of abuse, then the facility will go through proper channels of reporting (24 hour and 5 day report). No investigation, 24 hour or 5 day working report was completed.	F 607	informational reference card that can attach to the employee nametag. This reference card will contain a summary of information regarding abuse policies and reporting guidelines. These reference cards will be distributed at the Training Blitz sessions on April 3, 4 and 5th. Monitoring and QA: The Director Nursing and the Administrator are the persons assigned responsibility for ensuring the accepted Plan of Corrections is implemented fully. Following each investigation the administrator will complete an assessment checklist to ensure compliance with the facility's policies and guidelines regarding abuse reporting and investigation. This investigation checklist was implemented on March 12, 2018. An administrative nurse will review all nursing notes daily to ensure all possible incidents have been reported. Each day the administrative nurse will complete an audit sheet to document the task was completed. This daily audit was implemented on March 19, 2018 The Director of Nursing or Designee will audit/monitor these sheets each Friday in order to ensure compliance. This weekly audit started on March 23, 2018. The Social Worker is our facility abuse officer and has led the staff training portion of this POC. She is also responsible for providing staff with annual training on abuse policies. This plan and audit will be reviewed during the facility's	

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F 607	Continued From page 4 An interview was conducted with the Social Worker on 02/23/18 at 10:09 AM. She was responsible for completing a 24 hour and 5 day working report for instances in which a resident had an injury or bruise of unknown origin. She further revealed that she was the facility abuse officer and became aware of injuries or bruises of unknown origin verbally or by email. The SW revealed that she received and reviewed the incident report and concluded if the injury was suspicious in nature. She indicated that she did not believe the residents bruise (located on her nose) was not in a suspicious area and did not warrant a 24 hour or 5 day working report that was considered to be suspicious in nature. No investigation, 24 hour or 5 day working report was completed.	F 607	Quality Assurance Committee for a minimum of two quarters (October 2018). This corrective was fully implemented on March 23, 2018. Additional training with all staff will be completed by April 5th, 2018. Follow up training with the Administrative staff is scheduled for March 27, 2018.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in	F 609		3/23/18

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F 609	Continued From page 5 accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, resident, family, physician and staff interviews the facility failed to submit a 24 hour and 5 day report to the State Survey Agency and failed to investigate a bruise of unknown origin for 1 of 1 sampled Residents (Resident #36). Findings Included: Resident #36 was admitted on 12/10/17. Resident #36 has a diagnosis that included Non-Alzheimer's dementia, anemia, and seizure disorder. Review of the admission Minimum Data Set (MDS) dated 12/22/17 revealed that Resident #36 requires limited assistance for bed mobility, extensive assistance for transfers, total assistance with eating and total dependence with toileting. Resident #36 utilizes a wheelchair for ambulation and has no impairment indicated to upper and lower extremities. Resident #36 has a BIMS of 0 with short and long term memory problems. Resident #36 has moderate cognitive impairment with poor decision making, and requires cues and supervision.	F 609	The resident affected: An internal investigation regarding resident number 36 was completed by the social worker on February 27, 2018 and reviewed by the administrator. Resident, charge nurse, Assistant Director of Nursing and direct caregivers were all interviewed regarding potential resident abuse. The Residents Physician and Family were notified. The Social Worker, abuse officer, provided education on the facilities abuse policies and procedures regarding reporting, protection and investigation to all the individuals included in this investigation on February 27, 2018. The abuse policies were reviewed by administrative staff (Administrator, Social Worker, Director of Nursing and Administrative Nurses). This training was completed in the quality Measure meeting on Tuesday February 27, 2018. The Human Resource Officer is meeting with the Administrative team on March 27, 2018 to review abuse policies for a second time and audit for understanding. Also, copies of all the facility abuse policies were placed at each nursing station for employee review on	

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F 609	Continued From page 6 Review of care plan dated 12/13/17 revealed a problem/ onset of the resident receiving aspirin and was at risk for abnormal bleeding, bruising and hematomas. The goal indicates that the resident will be free from abnormal bleeding/ bruising. The interventions included administer medications as ordered, report accidents/ injuries to MD immediately and monitor for increased bruising/ bleeding/ swelling. Review of care plan dated 12/13/17 revealed a problem/ onset of the resident being at risk for falls related to history of falls, unsteady gait, impaired mobility and impaired cognition. The goal indicates that the resident will be free of falls. The interventions included keep call light within reach, complete falls risk assessment, encourage participation in PT and OT. Review of February 2018 Incident Log stated on 2/15/18 that Resident #36 had a hematoma, source unknown. Review of progress note dated 2/15/18 indicated that Resident #36 was noted to have a green bruise to bridge of nose of unknown origin. Resident #36 responsible party and MD were notified. Will continue to monitor and inquire as to reason. An observation on 02/19/18 at 12:53 PM revealed a 1 x 1.5 inch bruised area noted to bridge of nose, inner canthus to inner canthus and a reddened area under the right eye of Resident #36. An interview was conducted on 02/21/18 at 2:59 PM with nurse #1. The nurse revealed that the bruise to Resident #36 was of unknown origin.	F 609	February 27. Residents potentially affected: An audit of all residents was completed during the week of March 5, 2017. This included a head to toe skin check by a licensed nurse of all residents to identify bruising or potential abuse. No other areas of concern were identified during this audit. These audits were reviewed by the Quality Assurance Nurse for any area of concern. The abuse/investigation policies were reviewed by administrative staff (Administrator, Social Worker, Director of Nursing and Administrative Nurses). This training was completed in the quality Measure meeting on Tuesday February 27, 2018. The Human Resource Officer is meeting with the Administrative team on March 27, 2018 to review abuse policies for a second time and audit for understanding. A Training Blitz is scheduled for April 3, 4 and 5 for all staff (Nursing, dietary, Environmental Services, Activities). This training will include an abuse/investigation policy and procedure review. The facility has fully developed policies and procedures that address preventing abuse, neglect, and exploitation of residents and misappropriation of resident property. These procedures also address and define guidelines for protection, reporting and investigating. We will retrain all staff on these abuse policies and reporting requirements. We will also educate staff on the requirements regarding reporting and investigation of injuries of Unknown Origin or Suspicious	

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F 609	Continued From page 7 She telephoned Resident #36 family and made the Medical Director (MD) aware of the bruise. An incident report was completed. The nurse was unaware of how the bruising occurred. She verbalized that Resident #36 does become combative and resistive to care. Nurse #1 indicated that she did not notify the Director of Nursing (DON) or the Administrator of the bruise to Resident #36. Nurse #1 indicated that she will report bruising in the future to the DON and Administrator. She further revealed that Resident #36 has not had any falls to her knowledge. Nurse #1 verbalized that Resident #36 has had no changes in condition or regular routine; just the bruise. An interview was conducted on 02/22/18 at 7:43 AM with NA #1. She reported that Resident #36 had a bruise to the nurse when she returned from vacation. She returned to work Monday the week prior to Valentine's Day. The NA verbalized that Resident #36 can be combative/ resistive to care. NA #1 indicated that she was unaware of any falls. An interview was conducted on 02/22/18 at 8:35 AM with NA #2 revealed that she was not aware of bruising to Resident #36 until she was assisting in the Lakewood common area. The NA did not indicate what day she observed bruising. The NA questioned other staff in the common area as to what happened to Resident #36 face. She indicted that other staff were not aware. NA #2 verbalized that she did no further reporting. An interview was conducted on 02/22/18 at 8:58 AM with NA #3 revealed she first noticed the bruise on Resident #36 face on last week. She stated that she asked resident #36 assigned aide	F 609	injuries. Injuries of unknown origin or suspicious injuries must be immediately investigated to rule out abuse. This training will be led by the facility Social Worker. Systemic changes: An administrative nurse will review all nursing notes daily to ensure all possible incidents have been reported. Each day the administrative nurse will complete an audit sheet to document the task was completed. This daily audit was implemented on March 19, 2018 The Director of Nursing or Designee will audit/monitor these sheets each Friday in order to ensure compliance. This weekly audit started on March 23, 2018. Starting the Week of March 5th, 2018, a head to toe skin audit is completed of all residents on a weekly basis. This included a head to toe skin check by a licensed nurse of all residents to identify bruising or potential abuse. The skin checks coordinate with the resident's bath days. Nursing staff are expected to follow facility policies regarding abuse reporting regarding any area of concern noted. The quality measure Nurse is responsible for reviewing the audits weekly and monitoring for compliance. Each employee will be issued an informational reference card that can attach to the employee nametag. This reference card will contain a summary of information regarding abuse policies and	

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F 609	Continued From page 8 (NA #1) about the bruise. She did not recall what assigned aide (NA #1) stated. NA #3 did not further report bruise. An interview with the MD on 02/22/18 at 9:07 AM revealed that he was verbally notified regarding bruising to the face of Resident #36. The MD stated that the staff verbally informed him that the bruise Resident #36 had was from wearing glasses. The MD further revealed that notification from staff did not indicate that bruising was anything suspicious and did not place a notification in his MD Book. The MD further stated that he did not look at Resident #36 in regards to the bruise. The MD did not know if the resident wore glasses and did not assess her at the time of the incident. A follow up interview with Nurse #1 on 02/22/18 at 9:14 AM revealed that she was not aware of Resident #36 wearing glasses. The resident was not assessed at the time of the incident as to wearing glasses. A follow up interview with NA #1 on 02/22/18 at 9:24 revealed that Resident #36 does not wear glasses. NA #1 was not aware of Resident #36 having glasses. She verbalized that if Resident #36 had glasses she would not keep them on. An interview was conducted on 02/22/18 at 9:26 AM with NA #4. She stated that on Monday this week she noticed bruise to Resident #36 face while NA #2 was assisting Resident #36 with her meal. The nurse aide indicated that she asked the primary aide (NA #1) about the bruise and the primary aide (NA #1) was not aware of bruise. NA #4 further revealed that she reported bruise to Resident #36 nurse (Nurse #1). She verbalized	F 609	reporting guidelines. These reference cards will be distributed at the Training Blitz sessions on April 3, 4 and 5th. Monitoring and QA: The Director Nursing and the Administrator are the persons assigned responsibility for ensuring the accepted Plan of Corrections is implemented fully. Following each investigation the administrator will complete an assessment checklist to ensure compliance with the facility's policies and guidelines regarding abuse reporting and investigation. This investigation checklist was implemented on March 12, 2018. An administrative nurse will review all nursing notes daily to ensure all possible incidents have been reported. Each day the administrative nurse will complete an audit sheet to document the task was completed. This daily audit was implemented on March 19, 2018 The Director of Nursing or Designee will audit/monitor these sheets each Friday in order to ensure compliance. This weekly audit started on March 23, 2018. The Social Worker is our facility abuse officer and has led the staff training portion of this POC. She is also responsible for providing staff with annual training on abuse policies. This plan and audit will be reviewed during the facility's Quality Assurance Committee for a minimum of two quarters (October 2018). This corrective was fully implemented on March 23, 2018. Additional training with all	

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F 609	Continued From page 9 that she was not aware of the resident having any falls. NA #4 did state that Resident #36 can become combative. NA #4 verbalized that Resident #36 will grab at staff and will attempt to bite staff. She indicated that Resident #36 was easy to redirect with calm conversation and offering Resident #36 a stuffed animal. NA #4 revealed that she was not aware of Resident #36 wearing glasses. A telephone interview was conducted on 02/22/18 at 10:35 AM with family revealed that family was notified via text message from a private sitter regarding bruise on 2/17/2018. Family stated that the nurse verbalized that she would telephone her once the facility figured out what happened. Family indicated that no return call has been made. Family did not give any rationale as to cause of the bruise. Family was not aware or has been informed of Resident #36 having falls. Family also not aware of Resident #36 wearing glasses. Family indicated that Resident had a history of losing glasses at her last facility, so the family quit buying them. An interview was conducted on 02/22/18 at 11:17 AM with the DON. The DON revealed that she was notified about bruise on resident on 02/21/2019. She expects to be notified of any bruises along with family notification and md notification. The DON revealed that a nursing note should have been completed, as well as, an incident report. The DON reiterated that her expectation of staff when they have a bruise of unknown origin was to report to the DON and Administrator. The Social Worker (SW) would have also been notified to assist in the	F 609	staff will be completed by April 5th, 2018. Follow up training with the Administrative staff is scheduled for March 27, 2018.	

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F 609	Continued From page 10	F 609		

investigation. No investigation, 24 hour or 5 day working report was completed.

An interview with the Administrator on 02/22/18 at 02:21 PM revealed that her expectation of a bruise of unknown origin needs to be reported to the Social Worker (SW). If there are any suspicions of abuse, then the facility will go through proper channels of reporting (24 hour and 5 day report). No 24 hour or 5 day working report submitted per Administrator.

An interview with the Social Worker (SW) on 02/22/18 at 02:33 PM revealed that she became aware of bruise the afternoon of 2/15/18. The SW reviewed the incident report and completed notes at the bottom of the incident report. The facility made the determination that the incident did not warrant reporting of being a bruise of unknown origin. SW pulled up CMS Memo regarding abuse and reporting bruising of unknown origin to review. SW indicated that location of bruise did not meet definition of physical abuse.

A follow up interview was conducted with the Social Worker on 02/23/18 at 10:09 AM. She was responsible for completing a 24 hour and 5 day working report for instances in which a resident had an injury or bruise of unknown origin. She further revealed that she was the facility abuse officer. She became aware of injuries or bruises of unknown origin verbally or by email. The SW revealed that she received and reviewed the incident report and concluded if the injury was suspicious in nature. She indicated that she did not believe the residents bruise (located on her nose) was not in a suspicious area and did not warrant a 24 hour or 5 day

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F 609	Continued From page 11 working report that was considered to be suspicious in nature. The SW stated that she re-reviewed the CMS guidelines and stated it did not meet the requirements. She discussed the bruise with Nurse #1 that wrote the incident report. She further discussed the injury with the Assistant Director of Nursing. The SW verbalized that she assumed the resident might have received the bruise from her glasses, or the side rail. She indicated no discussions were held with nursing staff to determine if the resident was wearing glasses at the time. The SW assumed it could have been the glasses due to making an observation of a pair of glasses on the resident's bedside table. She did not validate if the glasses belonged to the resident or another resident with staff. She further revealed that she did not know if a side rail assessment was completed. She stated that no conclusion had been drawn or interventions to prevent what was assumed as a cause/result of the bruise. She further stated the resident was cognitively impaired and would not be able to communicate what occurred. The SW had not spoken with staff in regards to care provided or when they initially observed any bruising. The SW verbalized that the resident also had behaviors and could have hit herself. She stated there was no care plan in place for the behaviors of aggression. Review of medical record revealed no side rail assessment for date of incident. Review of care plans revealed no care plan for behaviors of aggression.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)	F 610		3/23/18

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F 610	Continued From page 12 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, resident, family, physician and staff interviews the facility failed to investigate a bruised area to bridge of nose, inner canthus to inner canthus and a reddened area under the right eye for 1 of 1 sampled Residents (Resident #36) for a bruise of unknown origin. Findings Include: Resident #36 was admitted on 12/10/17. Resident #36 has a diagnosis that included Non-Alzheimer's dementia, anemia, and seizure disorder. Review of the admission Minimum Data Set (MDS) dated 12/22/17 revealed that Resident #36 requires limited assistance for bed mobility, extensive assistance for transfers, total assistance with eating and total dependence with	F 610	The resident affected: An internal investigation regarding resident number 36 was completed by the social worker on February 27, 2018 and reviewed by the administrator. Resident, charge nurse, Assistant Director of Nursing and direct caregivers were all interviewed regarding potential resident abuse. The Residents Physician and Family were notified. The Social Worker, abuse officer, provided education on the facilities abuse policies and procedures regarding reporting, protection and investigation to all the individuals included in this investigation on February 27, 2018. The abuse policies were reviewed by administrative staff (Administrator, Social Worker, Director of Nursing and Administrative Nurses). This training was completed in the quality	

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F 610	Continued From page 13 toileting. Resident #36 utilizes a wheelchair for ambulation and has no impairment indicated to upper and lower extremities. Resident #36 has a BIMS of 0 with short and long term memory problems. Resident #36 has moderate cognitive impairment with poor decision making, and requires cues and supervision. Review of care plan dated 12/13/17 revealed a problem/ onset of the resident receiving aspirin and is at risk for abnormal bleeding, bruising and hematomas. The goal indicates that the resident will be free from abnormal bleeding/ bruising. The interventions included administer medications as ordered, report accidents/ injuries to MD immediately and monitor for increased bruising/ bleeding/ swelling. Review of care plan dated 12/13/17 revealed a problem/ onset of the resident being at risk for falls related to history of falls, unsteady gait, impaired mobility and impaired cognition. The goal indicates that the resident will be free of falls. The interventions included keep call light within reach, complete falls risk assessment, encourage participation in PT and OT. Review of progress note dated 2/15/18 revealed that Resident #36 was noted to have a green bruise to bridge of nose of unknown origin. Resident #36 responsible party and MD were notified. Will continue to monitor and inquire as to reason. Review of the February 2018 Incident Log stated on 2/15/18 that Resident #36 had a hematoma. The source, location and activity at the time of the incident was unknown. No equipment was indicated as involved in the incident. Immediate	F 610	Measure meeting on Tuesday February 27, 2018. The Human Resource Officer is meeting with the Administrative team on March 27, 2018 to review abuse policies for a second time and audit for understanding. Also, copies of all the facility abuse policies were placed at each nursing station for employee review on February 27. Residents potentially affected: An audit of all residents was completed during the week of March 5, 2017. This included a head to toe skin check by a licensed nurse of all residents to identify bruising or potential abuse. No other areas of concern were identified during this audit. These audits were reviewed by the Quality Assurance Nurse for any area of concern. The abuse/investigation policies were reviewed by administrative staff (Administrator, Social Worker, Director of Nursing and Administrative Nurses). This training was completed in the quality Measure meeting on Tuesday February 27, 2018. The Human Resource Officer is meeting with the Administrative team on March 27, 2018 to review abuse policies for a second time and audit for understanding. A Training Blitz is scheduled for April 3, 4 and 5 for all staff (Nursing, dietary, Environmental Services, Activities). This training will include an abuse/investigation policy and procedure review. The facility has fully developed policies and procedures that address preventing abuse, neglect, and exploitation of residents and misappropriation of resident	

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F 610	Continued From page 14 action taken by staff was an assessment completed of resident, family and physician notification made. Follow up notes on the incident report dated 2/15/2018 by the Social Worker revealed that she was made aware of the bruise of unknown origin and that resident was not an accurate historian. She further noted that the injury was not consistent with physical abuse due to the location and that no other bruising or injuries are noted at this time. She states that resident is on aspirin and is a high falls risk. Nursing also reports that resident flails her arms in an uncontrolled manner. The SW indicated that the resident does wear glasses at times for reading. She also stated that the resident has quarter upper bed rails that could account for injury. An observation made by surveyor on 02/19/18 at 12:53 PM revealed a 1 x 1.5 inch bruised area noted to bridge of nose, inner canthus to inner canthus and a reddened area under the right eye of Resident #36. An interview was conducted on 02/21/18 at 2:59 PM with nurse #1. The nurse revealed that the bruise to Resident #36 was of unknown origin. She telephoned Resident #36 family and made the Medical Director (MD) aware of the bruise. An incident report was completed. The nurse was unaware of how the bruising occurred. She verbalized that Resident #36 does become combative and resistive to care. Nurse #1 indicated that she did not notify the Director of Nursing (DON) or the Administrator of the bruise to Resident #36. She indicated that she will report bruising in the future to the DON and Administrator. She further revealed that Resident #36 has not had any falls to her knowledge.	F 610	property. These procedures also address and define guidelines for protection, reporting and investigating. We will retrain all staff on these abuse policies and reporting requirements. We will also educate staff on the requirements regarding reporting and investigation of injuries of Unknown Origin or Suspicious injuries. Injuries of unknown origin or suspicious injuries must be immediately investigated to rule out abuse. This training will be led by the facility Social Worker. Systemic changes: An administrative nurse will review all nursing notes daily to ensure all possible incidents have been reported. Each day the administrative nurse will complete an audit sheet to document the task was completed. This daily audit was implemented on March 19, 2018 The Director of Nursing or Designee will audit/monitor these sheets each Friday in order to ensure compliance. This weekly audit started on March 23, 2018. Starting the Week of March 5th, 2018, a head to toe skin audit is completed of all residents on a weekly basis. This included a head to toe skin check by a licensed nurse of all residents to identify bruising or potential abuse. The skin checks coordinate with the resident's bath days. Nursing staff are expected to follow facility policies regarding abuse reporting regarding any area of concern noted. The quality measure Nurse is responsible for	

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F 610	Continued From page 15 Nurse #1 verbalized that Resident #36 has had no changes in condition or regular routine; just the bruise. An interview was conducted on 02/22/18 at 7:43 AM with NA #1. She reported that Resident #36 had a bruise to the nurse when she returned from vacation. She returned to work Monday the week prior to Valentine's Day. The NA verbalized that Resident #36 can be combative/ resistive to care. NA #1 indicated that she was unaware of any falls. An interview with the MD on 02/22/18 at 9:07 AM revealed that he was verbally notified regarding bruising to the face of Resident #36. The MD did not know if the resident wore glasses and did not assess her at the time of the incident. A follow up interview with Nurse #1 on 02/22/18 at 9:14 AM revealed that she was not aware of Resident #36 wearing glasses. The resident was not assessed at the time of the incident as to wearing glasses. A follow up interview with NA #1 on 02/22/18 at 9:24 revealed that Resident #36 does not wear glasses. NA #1 was not aware of Resident #36 having glasses. She verbalized that if Resident #36 had glasses she would not keep them on. An interview was conducted on 02/22/18 at 9:26 AM with NA #4. She stated that Resident #36 can become combative. NA #4 verbalized that Resident #36 will grab at staff and will attempt to bite staff. She indicated that Resident #36 was easy to redirect with calm conversation and offering Resident #36 a stuffed animal. NA #4 revealed that she was not aware of Resident #36	F 610	reviewing the audits weekly and monitoring for compliance. Each employee will be issued an informational reference card that can attach to the employee nametag. This reference card will contain a summary of information regarding abuse policies and reporting guidelines. These reference cards will be distributed at the Training Blitz sessions on April 3, 4 and 5th. Monitoring and QA: The Director Nursing and the Administrator are the persons assigned responsibility for ensuring the accepted Plan of Corrections is implemented fully. Following each investigation the administrator will complete an assessment checklist to ensure compliance with the facility's policies and guidelines regarding abuse reporting and investigation. This investigation checklist was implemented on March 12, 2018. An administrative nurse will review all nursing notes daily to ensure all possible incidents have been reported. Each day the administrative nurse will complete an audit sheet to document the task was completed. This daily audit was implemented on March 19, 2018 The Director of Nursing or Designee will audit/monitor these sheets each Friday in order to ensure compliance. This weekly audit started on March 23, 2018. The Social Worker is our facility abuse officer and has led the staff training	

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F 610	Continued From page 16 wearing glasses. A telephone interview was conducted on 02/22/18 at 10:35 AM with family. The family stated that the nurse verbalized that she would telephone her once the facility figured out what happened. The family indicated that no return call has been made. The family did not give any rationale as to cause of the bruise. The family was not aware or has been informed of Resident #36 having falls. Family also not aware of Resident #36 wearing glasses. Family indicated that Resident had a history of losing glasses at her last facility, so the family quit buying them. An interview was conducted on 02/22/18 at 11:17 AM with the DON. The DON revealed that she was notified about bruise on resident on 02/21/2019. She expects to be notified of any bruises along with family notification and md notification. The DON revealed that a nursing note should have been completed, as well as, an incident report. The DON reiterated that her expectation of staff when they have a bruise of unknown origin was to report to the DON and Administrator. The Social Worker (SW) would have also been notified to assist in the investigation. No investigation, 24 hour or 5 day working report was completed. An interview with the Administrator on 02/22/18 at 02:21 PM revealed that her expectation of a bruise of unknown origin needs to be reported to the Social Worker (SW). If there are any suspicions of abuse, then the facility will go through proper channels of reporting (24 hour and 5 day report). No 24 hour or 5 day working report submitted per Administrator. No investigation completed.	F 610	portion of this POC. She is also responsible for providing staff with annual training on abuse policies. This plan and audit will be reviewed during the facility's Quality Assurance Committee for a minimum of two quarters (October 2018). This corrective was fully implemented on March 23, 2018. Additional training with all staff will be completed by April 5th, 2018. Follow up training with the Administrative staff is scheduled for March 27, 2018.	

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F 610	Continued From page 17	F 610		

An interview with the Social Worker (SW) on 02/22/18 at 02:33 PM revealed that she became aware of bruise the afternoon of 2/15/18. The SW reviewed the incident report and completed notes at the bottom of the incident report. The facility made the determination that the incident did not warrant reporting of being a bruise of unknown origin. SW pulled up CMS Memo regarding abuse and reporting bruising of unknown origin to review. SW indicated that location of bruise did not meet definition of physical abuse.

A follow up interview was conducted with the Social Worker on 02/23/18 at 10:09 AM. She was responsible for completing a 24 hour and 5 day working report for instances in which a resident had an injury or bruise of unknown origin. She further revealed that she was the facility abuse officer. She became aware of injuries or bruises of unknown origin verbally or by email. The SW revealed that she received and reviewed the incident report and concluded if the injury was suspicious in nature. She indicated that she did not believe the residents bruise (located on her nose) was not in a suspicious area and did not warrant a 24 hour or 5 day working report that was considered to be suspicious in nature. The SW stated that she re-reviewed the CMS guidelines and stated it did not meet the requirements. She discussed the bruise with Nurse #1 that wrote the incident report. She further discussed the injury with the Assistant Director of Nursing. The SW verbalized that she assumed the resident might have received the bruise from her glasses, or the side rail. She indicated no discussions were held with nursing staff to determine if the resident was

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F 610	Continued From page 18 wearing glasses at the time. The SW assumed it could have been the glasses due to making an observation of a pair of glasses on the resident's bedside table. She did not validate if the glasses belonged to the resident or another resident with staff. She further revealed that she did not know if a side rail assessment was completed. She stated that no conclusion had been drawn or interventions to prevent what was assumed as a cause/result of the bruise. She further stated the resident was cognitively impaired and would not be able to communicate what occurred. The SW had not spoken with staff in regards to care provided or when they initially observed any bruising. The SW verbalized that the resident also had behaviors and could have hit herself. She stated there was no care plan in place for the behaviors of aggression. Review of medical record revealed no side rail assessment for date of incident. Review of care plans revealed no care plan for behaviors of aggression.	F 610		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews, and record reviews the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of skin conditions for pressure ulcers (Resident #12) and failed to accurately code behavior symptoms (Resident # 36) for 2 of 19 sampled residents.	F 641	The resident affected: An MDS modification was completed on resident #12 on March 13, 2018 in order to accurately code the MDS assessment in the area of skin conditions for Pressure ulcers. A MDS modification was	3/23/18

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F 641	Continued From page 19 Findings included: Resident #12 was admitted to the facility on 11/07/17 with a diagnoses that included dementia, orthostatic hypotension, coronary artery and chronic kidney disease. A review of the most recent (MDS) dated 02/14/18, coded as a quarterly assessment, assessed Resident #12 at risk for developing pressure ulcer and as having no unhealed pressure ulcers. The MDS further revealed Resident #12 required extensive assistance with mobility and was cognitively impaired. A review of the facilities Wound/Skin Healing Record for resident #12 dated 01/30/18 revealed a Stage 2 pressure ulcer on left buttock. A review of Resident # 12's nurses note on 02/11/18 documented a two centimeter Stage two pressure ulcer on left buttock. An interview with the MDS nurse was conducted on 02/22/18 at 1:56 pm. During this interview she revealed she completed the quarterly assessment for Resident #12. The MDS nurse stated the system failed to pull the new order for the pressure ulcer during the look back period, so the order was missed and the assessment was not coded correctly. An interview with the Director of Nursing (DON) was completed on 02/22/18 at 2:09 pm. During this interview she stated she expected the MDS to be coded correctly.	F 641	completed for resident #36 on March 13, 2018 in order to accurately code the MDS assessment in the area of accurately coded behavior symptoms. Both care plans have been updated to reflect accurate assessments. Residents potentially affected: During or weekly quality measures meeting on February 27, 2018, the IDT reviewed the pressure ulcer report and made sure MDS and careplans were updated to accurately reflect pressure ulcers. We also audited all residents receiving anti-anxiety and anti-psychotic medications to ensure the MDS and Careplanes accurately addressed behaviors. The plan of correction for this deficiency includes retraining for the Interdisciplinary care plan team on MDS coding, CAA process, care planning and RAI overview. The MDS Coordinator attended state approved training on February 22, 2018. She will be responsible for training the IDT. This training was completed on March 20, 2018. Nursing staff were reeducated on proper behavior/skin condition changes documentation and reporting to the Interdisciplinary care plan team. We have also created an internal user group email to make communication easy. This notice was provided to all nursing staff via our message board on March 5th, 2018. A Training Blitz is scheduled for April 3, 4 and 5 for all staff which will include further education on communication expectations and reporting of behaviors and skin condition changes.	

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F 641	Continued From page 20 2. Resident #36 was admitted on 12/10/17. Resident #36 has a diagnosis that included Non-Alzheimer's dementia, anemia, and seizure disorder. Review of the admission Minimum Data Set (MDS) dated 12/22/17 revealed that Resident #36 has a BIMS of 0 with short and long term memory problems. Resident #36 has moderate cognitive impairment with poor decision making, and requires cues and supervision. Resident #36 had no behavioral symptoms coded. Review of the Treatment Administration Record dated December 2017 revealed that resident had behavioral symptoms exhibited 12/16/18 through 12/22/18 on the first and second shift. The symptoms were coded on the Treatment Administration Record as anxiousness, grabbing, swinging at others/ staff, hitting, kicking, rummaging and agitation without harm to self or others. An interview with the Social Worker (SW) on 02/23/18 at 10:09 AM revealed that she completes Section E- Behaviors of the Minimum Data Set (MDS). The SW verbalized that she was aware that Resident #36 has behaviors. She stated that she did not code any behaviors during the assessment period because there were no nursing notes to support the coding of behaviors.	F 641	Systematic Changes: An administrative nurse will review all nursing notes daily to ensure all new skin issues and behaviors have been appropriately reported. Each day the administrative nurse will complete an audit sheet to document the task was completed. This daily audit was implemented on March 19, 2018 The Director of Nursing or Designee will audit/monitor these sheets each Friday in order to ensure compliance. This weekly audit started on March 23, 2018. Starting the Week of March 5th, 2018, a head to toe skin audit is completed of all residents on a weekly basis. This included a head to toe skin check by a licensed nurse of all residents to identify any change in skin condition. The skin checks coordinate with the resident's bath days. The quality measure Nurse is responsible for reviewing the audits weekly and monitoring for compliance. Monitoring and QA: In order to monitor our plan of correction for efficiency, each Tuesday we will have a quality measures meeting that consist of the following staff: Administrator, Director of Nursing, and Assistant Director of Nursing, MDS nurses, Quality Assurance Nurse, Social Worker, and Dietitian. This time together will be utilized to review all facility wounds, behaviors, weight loss, psychotropic medication use, and falls. This will allow for an IDT discussion on appropriate care plans, assessments and interventions. This meeting will allow for an exchange of information that permits the MDS nurse the opportunity to capture information	

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F 641	Continued From page 21 She further explained that she did not use staff interviews or other documentation from the medical record when coding Section E- Behaviors of the MDS. An interview with the Administrator on 02/23/18 at 10:40 AM revealed that her expectation was that staff review all information and properly code the MDS.	F 641	needed to accurately code the MDS assessment and update care plans in all areas. These meetings began on February 27, 2018. The facility will monitor its performance to make sure the solutions outlined above are sustained, and the corrective action is evaluated for effectiveness by the Director of Nursing. This plan will be reviewed during the facility's Quality Assurance Committee for a minimum of two quarters (October 2018). This corrective action will be fully implemented by March 23, 2018.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656		3/23/18

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	345235	A. BUILDING _____ B. WING _____	02/23/2018

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F 656	Continued From page 22 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to develop a care plan to address weight loss for a resident with significant weight loss for 1 of 3 sampled residents (Resident 71). The findings included: Resident #71 was admitted to the facility on 01/12/18 with diagnoses that included moderate protein calorie malnutrition, irritable bowel, gastroesophageal reflux disease and others. The most recent Minimum Data Set (MDS) dated 02/10/18 specified the resident had intact cognition and had experienced a significant weight loss of 16.98% in 1 month. Review of Resident #71's medical record revealed that her care plan was reviewed and updated on 02/10/18 by the interdisciplinary team.	F 656	The Resident affected: The care plan for resident #71 was updated to reflect weight loss on February 22, 2018. Residents potentially affected: During our weekly Quality Measures meeting, the IDT reviewed all residents with significant weight loss for February 2018. Careplans were audited and updated as appropriate. The plan of correction for this deficiency includes retraining for the Interdisciplinary care plan team on MDS coding, CAA process, care planning and RAI overview. The MDS Coordinator attended state approved training on February 22, 2018. She will be responsible for training the IDT. This training was completed on March 20, 2018. Systematic Changes: Dietitian will review weights on an ongoing basis and discuss	

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F 656	Continued From page 23 Further review of Resident #71's care plan revealed the resident did not have a care plan to address the weight loss and did not have any dietary assessments. An interview on 02/21/18 at 11:24 am with the Registered Dietician (RD) revealed she is responsible for monitoring weights on all residents and entering all nutritional information on the MDS. The RD also revealed she monitored all weights once a month on a significant weight change report. The RD stated the February significant weight change report did not capture Resident #71's decreased weight. The RD revealed she updated the MDS dated 02/10/18 as having significant weight loss but didn't initiate a care plan. She further stated Resident #71 fell through the cracks. An interview on 02/21/18 at 2:49 pm with MDS Coordinator #1 revealed she is responsible for her own portion of the MDS and the other disciplines are responsible for their own sections. She further stated she reviewed the entire MDS for completion but didn't necessarily review what was inputted. MDS Coordinator #1 also reported once a discipline completed their portion of the MDS, they would go into the care assessment and write a care plan. An interview on 02/22/18 at 8:44 am with the Medical Doctor (MD) revealed he expected a weight loss that significant from Resident #71. The MD stated Resident #71 came to the facility from the hospital obtunded, not eating and pumped full of fluids. He further revealed he was verbally made aware of the significant weight change by the floor nurse.	F 656	weight changes in our weekly quality measures meeting. Each week we will have a quality measures meeting that consist of the following staff: Administrator, Director of Nursing, and Assistant Director of Nursing, MDS nurses, Quality Assurance Nurse, Social Worker, and Dietitian. This time together will be utilized to review all facility wounds, behaviors, weight loss, psychotropic medication use, and falls. This will allow for an IDT discussion on appropriate care plans, assessments and interventions. This meeting will allow for an exchange of information that permits the MDS nurse the opportunity to capture information needed to accurately code the MDS assessment and update care plans in all areas. Monitoring and QA: In order to monitor our plan of correction for efficiency, the dietician will submit a weight change report to the MDS Coordinator and Director of Nursing on monthly basis. The MDS Coordinator will review care plans for accuracy regarding weight loss. The facility will monitor its performance to make sure the solutions outlined above are sustained, and the corrective action is evaluated for effectiveness by the Director of Nursing. This plan will be reviewed during the facility's Quality Assurance Committee for a minimum of two quarters (October 2018). This corrective action will be fully implemented by March 23, 2018.	

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F 656	Continued From page 24 An interview on 02/23/18 at 10:35 am with the Director of Nursing (DON) and the Administrator both revealed it was their expectation any resident with significant weight loss should have a care plan. The Administrator stated it was her expectation the MDS Coordinator review the entire MDS and make sure care plans were created.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 657		3/23/18

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F 657	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to revise a comprehensive care plan for a resident who developed a facility acquired stage 2 pressure ulcer for 1 of 1 residents reviewed for pressure ulcers (Resident #12). The findings included: Resident #12 was admitted to the facility on 11/07/17 with diagnoses that included dementia, orthostatic hypotension, coronary artery disease and chronic kidney disease. A review of the most recent MDS dated 02/14/18, coded as a quarterly assessment, assessed Resident #12 at risk for developing pressure ulcer and as having no unhealed pressure ulcers. The MDS further revealed Resident #12 required extensive assistance with mobility and was cognitively impaired. A review of Resident #12's comprehensive care plan, most recently revised on 02/14/18, revealed no plan of care for Resident #12's documented stage 2 pressure ulcer. The care plan indicated the resident was at risk for skin breakdown due to impaired mobility, dementia and incontinence. The approaches included assist with mobility, transfers and complete skin assessment quarterly. A review of the facilities Wound/Skin Healing Record dated 01/30/18 revealed a stage 2 pressure ulcer on residents left buttock. A review of Hospice wound care treatment order dated 01/31/18, indicated a treatment of	F 657	Resident affected: The Care plan was updated for resident #12 on February 22, 2018 in order to accurately reflect the change in area of skin conditions for Pressure ulcers. Residents potentially affected: During our weekly quality measures meeting on February 27, 2018, the IDT reviewed the pressure ulcer report and made sure MDS and careplans were updated to accurately reflect pressure ulcers. The plan of correction for this deficiency includes retraining for the Interdisciplinary care plan team on MDS coding, CAA process, care planning and RAI overview. The MDS Coordinator attended state approved training on February 22, 2018. She will be responsible for training the IDT. This training was completed on March 20, 2018. Nursing staff were reeducated on proper skin condition changes documentation and reporting to the Interdisciplinary care plan team. We have also created an internal user group email to make communication easy. This notice was provided to all nursing staff via our message board on March 5th, 2018. A Training Blitz is scheduled for April 3, 4 and 5 for all staff which will include further education on communication expectations and reporting of skin condition changes. Systematic Changes: An administrative nurse will review all nursing notes daily to ensure all new skin issues and behaviors have been appropriately reported. Each day the administrative nurse will complete	

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F 657	Continued From page 26 dermacloud topical cream applied as needed to left buttock stage 2 pressure ulcer. Resident #12's nurses note dated 02/11/18 documented a two centimeter Stage two pressure ulcer on left buttock. Review of Physician Order dated 02/16/18 revealed a order to clean with normal saline, apply medi-honey ointment and cover with foam dressing daily. An interview was conducted with the MDS nurse on 02/21/18 at 3:00 pm. During this interview she stated she updated the care plan, but did not revise the care plan to include the development of Resident #12's Stage 2 pressure ulcer. An interview with the Director of Nursing (DON) was conducted on 02/22/18 at 2:09 pm. The DON stated she expected care plans to be updated for any new pressure ulcer.	F 657	an audit sheet to document the task was completed. This daily audit was implemented on March 19, 2018 The Director of Nursing or Designee will audit/monitor these sheets each Friday in order to ensure compliance. This weekly audit started on March 23, 2018. Starting the Week of March 5th, 2018, a head to toe skin audit is completed of all residents on a weekly basis. This included a head to toe skin check by a licensed nurse of all residents to identify any change in skin condition. The skin checks coordinate with the resident□s bath days. The quality measure Nurse is responsible for reviewing the audits weekly and monitoring for compliance. Monitoring and QA: In order to monitor our plan of correction for efficiency, each Tuesday we will have a quality measures meeting that consist of the following staff: Administrator, Director of Nursing, and Assistant Director of Nursing, MDS nurses, Quality Assurance Nurse, Social Worker, and Dietitian. This time together will be utilized to review all facility wounds, behaviors, weight loss, psychotropic medication use, and falls. This will allow for an IDT discussion on appropriate care plans, assessments and interventions. This meeting will allow for an exchange of information that permits the MDS nurse the opportunity to capture information needed to accurately code the MDS assessment and update care plans in all areas. These meeting began on February 27, 2018. The facility will monitor its performance to	

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F 657	Continued From page 27	F 657		

make sure the solutions outlined above are sustained, and the corrective action is evaluated for effectiveness by the Director of Nursing. This plan will be reviewed during the facility□s Quality Assurance Committee for a minimum of two quarters (October 2018). This corrective action will be fully implemented by March 23, 2018.

In order to monitor our plan of correction for efficiency, each week we will have a quality measures meeting that consist of the following staff: Administrator, Director of Nursing, Assistant Director of Nursing, MDS nurses, Quality Assurance Nurse, Social Worker, and Dietitian. This time together will be utilized to review all facility wounds, behaviors, weight loss, psychotropic medication use, and falls. This will allow for an IDT discussion on appropriate care plans, assessments and interventions. This meeting will allow for an exchange of information that permits the MDS nurse the opportunity to capture information needed to accurately code the MDS assessment and update care plans in all areas.
In order to monitor our plan of correction for efficiency, the Quality Assurance nurse will submit a weekly wound report (at each quality measures meeting) to the MDS Coordinator and Director of Nursing. The MDS Coordinator will review care plans for accuracy regarding skin changes.
The facility will monitor its performance to make sure the solutions outlined above are sustained, and the corrective action is evaluated for effectiveness by the Director

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F 657	Continued From page 28	F 657	of Nursing. This plan will be reviewed during the facility□s Quality Assurance Committee for a minimum of two quarters (October 2018). This corrective action will be fully implemented by April 13, 2018.	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 732		3/1/18

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F 732	Continued From page 29 §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to post the nurse staffing information for the second and third floors out of three floors in an area visible to residents and visitors. Findings included: On 02/19/18 at 10:45 AM an initial morning tour of the building revealed no staff posting on the second floor and the third floor of the facility. On 02/19/18 at 5:15 PM an afternoon tour of facility revealed no staff posting on the second floor and the third floor of the facility. On 02/20/18 at 8:34 AM a morning tour of the building revealed no staff posting on the second floor and the third floor of the facility. On 02/20/18 at 3:57 PM an afternoon tour of facility revealed no staff posting on the second floor and the third floor of the facility. An interview on 02/20/18 at 4:13 PM with the Director of Nursing revealed that the facility used daily staffing sheets and they are located adjacent from the nurse's stations. The daily staffing sheets included a breakdown of nurses and nurse assistants scheduled by name per unit per shift. The Director of Nursing further indicated that a separate sheet was not used to	F 732	The staffing sheets were present and posted on the second and third floors during the survey period. These sheets reflected the facility name, current date, scheduled staff (RNs, LPNs and CNAs), and Resident Census. What was not reflected on the sheet was the total number and the actual hours worked by those staff members identified on the staffing sheet. The staffing sheet was updated to include all the required information on February 21, 2018. These updated staffing sheets are posted daily in each household by the Third Shift Nurse. The Lakewood Neighborhood Nurse Supervisor is tasked with adjusting posting to reflect schedule changes. At the end of each 24 hour period the sheets are provided to the Director of Nursing in order to monitor for compliance and accuracy. The facility will monitor its performance to make sure the solutions outlined above are sustained, and the corrective action is evaluated for effectiveness by the Director of Nursing. This plan will be reviewed during the facility's Quality Assurance Committee for a minimum of two quarters (October 2018). This corrective action was fully implemented.	

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F 732	Continued From page 30 show daily nursing hours per shift. In an observation the Director of Nursing and surveyor walked to the nurse's station to review the sheet that was posted. The daily staffing sheet was not reflective of total nursing hours on a daily basis per shift. The Director of Nursing verbalized that she was responsible for completing the daily nurse staffing and the information had not been completed and posted. An interview on 02/20/18 at 04:34 PM with the Administrator revealed that daily staffing sheets were updated and daily nursing hours were left off of the current sheet being used. The Administrator's expectation was daily staffing sheets are updated to include daily nursing hours and posted daily.	F 732		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented	F 758		3/23/18

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F 758	Continued From page 31 in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure physician's orders for as needed (PRN) psychotropic medications were time limited in duration for 1 of 1 residents (Resident #11) reviewed for unnecessary medications. The finding included: 1. Resident #11 was admitted to facility on	F 758	Resident affected: On February 22, 2018 the physician came to the facility to evaluate resident #11 and the need for the PRN Xanax. The physician determined that the resident needs to continue use of the medication for a timeframe of six months. New order was clarified by the Assistant Director of Nursing. Physician was reeducated via phone by the	

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F 758	Continued From page 32 08/10/2017 with diagnoses that included Anxiety Disorder, unspecified, Parkinson's Disease, Unspecified Dementia without behavioral disturbance, Major depressive disorder, single episode, unspecified, Systemic atrophy, Alzheimer's Disease, unspecified, Enlarged prostate without lower urinary tract symptoms. The annual minimum data set (MDS) dated 08/23/2017 (Admission) indicated Resident #11 was moderately impaired. There were no behaviors or rejection of care noted. Resident #11 received an antianxiety medication on 2 of 7 days during the MDS period. A review of Physicians orders dated 02/06/2018 revealed Xanax 0.25 mg, ½ tab to be given on an as needed (PRN) basis. There was not a stop date for this PRN Xanax ordered. A review of Physician's progress notes dated, 2/14/18, quote, "needs prn Xanax indefinitely for intermittent agitation." Review of Consultant Pharmacist Progress Note dated, 2/7/2018, revealed, MD wants to keep PRN Alprazolam for severe agitation d/t to patient's status. (Hospice) An interview was conducted with the Director of Nursing (DON) on 2/21/2018 at 4:48 PM. She stated her expectation was to follow the regulations. Further stated, "each Administrative person has been made aware of the regulations, we discuss weekly, I would have expected with the word "indefinitely" would have brought this to the attention of the MD." An interview was conducted with the Medical Director (Facility MD) on 2/22/2018 at 9:02 AM. MD stated "I am aware of the new regulation, with	F 758	administrator and survey team on February 22, 2018. Resident potentially affected: An audit of all current orders was completed to ensure compliance with this regulation. This was completed by March 15, 2018. All administrative nursing staff and the medical director were reeducated on the new regulation regarding PRN orders for psychotropic drugs by the Administrator on February 22, 2018. All nurses will be educated at the Training Blitz scheduled for April 3, 4, and 5th, they will be expected to know these orders need to be limited to 14 days unless otherwise indicated with a timeframe no longer than 6 months. Each nurse will be expected to monitor compliance when new orders are initiated. Systemic changes: All administrative nursing staff and the medical director were reeducated on the new regulation regarding PRN orders for psychotropic drugs by the Administrator on February 22, 2018. All nurses will be educated at the Training Blitz scheduled for April 3, 4, and 5th, they will be expected to know these orders need to be limited to 14 days unless otherwise indicated with a timeframe no longer than 6 months. Each nurse will be expected to monitor compliance when new orders are initiated. All PRN psychotropic medications will entered with a 14 day stop date unless another approved timeframe is indicated by the physician. Monitoring: The ADON, or designee, will run a weekly report of all new orders to	

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F 758	Continued From page 33 all this flu going on and the residents going in and out of the facility, it got away from me, but, before I leave here today, all orders will be checked and will remain up to date from this day forward."	F 758	ensure compliance. This report will be reviewed at the weekly quality measures meeting. In addition, the pharmacy consultant will audit all PRN psychotropic orders during the monthly review to ensure compliance. The facility will monitor its performance to make sure the solutions outlined above are sustained, and the corrective action is evaluated for effectiveness by the Director of Nursing. This plan will be reviewed during the facility's Quality Assurance Committee for a minimum of two quarters (October 2018). This corrective action will be fully implemented by March 23, 2018.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put in to place in February 2017. This was for two recited deficiencies which were originally cited in January 2017 during a recertification survey and was subsequently recited in February 2018 on an annual recertification survey. The deficiencies were in the areas of accuracy of assessments and development of comprehensive care plans. The	F 867	F867 Resident affected: The Care plan was updated for resident #12 on February 22, 2018 in order to accurately reflect the change in area of skin conditions for Pressure ulcers. The care plan for resident #71 was updated to reflect weight loss on February 22, 2018. An MDS modification was completed on resident #12 on March 13, 2018 in order to accurately code the MDS assessment in	3/23/18

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F 867	Continued From page 34 continued failure of the facility during two federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program. The finding included: This tag is cross referenced to: F641 MDS accuracy: Based on staff interviews and record reviews the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of skin conditions for pressure ulcers (Resident #12) and failed to accurately code behavior symptoms (Resident #36) for 2 of 19 sampled residents. During the recertification survey of 01/12/17 the facility was cited for failing to accurately code the MDS for Level II Preadmission Screening and Resident Review for 1 of 1 sampled residents (Resident #38). F656 Care Plan: Based on record review and staff interview the facility failed to develop a care plan to address weight loss for a resident with significant weight loss for 1 of 3 sampled residents (Resident 71). During the recertification survey of 01/12/17 the facility was cited for failure to develop a comprehensive care plan to address the use of an anticoagulant medication (used to prevent the formation of blood clots) for 1 of 6 sampled residents (Resident #47) reviewed for unnecessary medications. An interview on 02/23/18 at 12:31 pm with the Administrator revealed they had followed their	F 867	the area of skin conditions for Pressure ulcers. A MDS modification was completed for resident #36 on March 13, 2018 in order to accurately code the MDS assessment in the area of accurately coded behavior symptoms. Both care plans have been updated to reflect accurate assessments. Potential Residents affected: During our weekly quality measures meeting on February 27, 2018, the IDT reviewed the pressure ulcer report and made sure MDS and care plans were updated to accurately reflect pressure ulcers. We also audited all residents receiving anti-anxiety and anti-psychotic medications to ensure the MDS and Care planes accurately addressed behaviors. The plan of correction for this deficiency includes retraining for the Interdisciplinary care plan team on MDS coding, CAA process, care planning and RAI overview. The MDS Coordinator attended state approved training on February 22, 2018. She will be responsible for training the IDT. This training was completed on March 20, 2018. During our weekly Quality Measures meeting, the IDT reviewed all residents with significant weight loss for February 2018. Careplans were audited and updated as appropriate. The plan of correction for this deficiency includes retraining for the Interdisciplinary care plan team on MDS coding, CAA process, care planning and RAI overview. The MDS Coordinator attended state approved training on February 22, 2018. She will be responsible for training the IDT. This training was completed on	

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F 867	Continued From page 35 plan of correction for two quarters but stopped after there were no issues.	F 867	March 20, 2018. Systematic Changes: An administrative nurse will review all nursing notes daily to ensure all new skin issues and behaviors have been appropriately reported. Each day the administrative nurse will complete an audit sheet to document the task was completed. This daily audit was implemented on March 19, 2018 The Director of Nursing or Designee will audit/monitor these sheets each Friday in order to ensure compliance. This weekly audit started on March 23, 2018. Starting the Week of March 5th, 2018, a head to toe skin audit is completed of all residents on a weekly basis. This included a head to toe skin check by a licensed nurse of all residents to identify any change in skin condition. The skin checks coordinate with the resident's bath days. The quality measure Nurse is responsible for reviewing the audits weekly and monitoring for compliance. Dietitian will review weights on a weekly basis and discuss weight changes in our weekly quality measures meeting. Each week we will have a quality measures meeting that consist of the following staff: Administrator, Director of Nursing, and Assistant Director of Nursing, MDS nurses, Quality Assurance Nurse, Social Worker, and Dietitian. This time together will be utilized to review all facility wounds, behaviors, weight loss, psychotropic medication use, and falls. This will allow for an IDT discussion on appropriate care	

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F 867	Continued From page 36	F 867		

plans, assessments and interventions. This meeting will allow for an exchange of information that permits the MDS nurse the opportunity to capture information needed to accurately code the MDS assessment and update care plans in all areas.

Monitoring and QA:
In order to monitor our plan of correction for efficiency, each Tuesday we will have a quality measures meeting that consist of the following staff: Administrator, Director of Nursing, and Assistant Director of Nursing, MDS nurses, Quality Assurance Nurse, Social Worker, and Dietitian. This time together will be utilized to review all facility wounds, behaviors, weight loss, psychotropic medication use, and falls. This will allow for an IDT discussion on appropriate care plans, assessments and interventions. This meeting will allow for an exchange of information that permits the MDS nurse the opportunity to capture information needed to accurately code the MDS assessment and update care plans in all areas. These meeting began on February 27, 2018.
The facility will monitor its performance to make sure the solutions outlined above are sustained, and the corrective action is evaluated for effectiveness by the Director of Nursing. Minutes from the Quality Measure meeting will be reviewed quarterly for trends, problems, training needs, and opportunities for improvement. This analysis will be reviewed in QA. This plan will be reviewed during the facility's

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F 867	Continued From page 37	F 867	Quality Assurance Committee for a minimum of four quarters (April 2019). This corrective action will be fully implemented by March 23, 2018	