STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345128	A. BUILDING _____ B. WING _____	05/19/2018

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BRIAN CENTER HEALTH & REHABILITATION/STATESVILLE	520 VALLEY STREET STATESVILLE, NC 28677

(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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity 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. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		6/16/18

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

Electronically Signed | 06/14/2018

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F 550	Continued From page 1 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, and staff interviews the facility failed to treat a resident in a dignified manner by not removing the resident from the bed pan for an extended period of time for 1 of 3 residents sampled for incontinence care (Resident #150). The findings included: Resident #150 was admitted to the facility on 05/04/18 with diagnoses that included acquired deformity of foot, osteomyelitis, heart failure, peripheral vascular disease, neurogenic bladder, and diabetes mellitus. Review of a comprehensive Minimum Data Set (MDS) dated 05/11/18 revealed that Resident #150 was cognitively intact and required extensive assistance of 2 staff members with toileting and transfers. The MDS further indicated that Resident #150 was frequently incontinent of bowel and had an indwelling catheter. The MDS also indicated that Resident #150 had impaired vision with no corrective lenses. An observation and interview was conducted with Resident #150 on 05/17/18 at 4:41 PM. Medication Aide (MA) #1 had prepared his medication and entered Resident #150's room. Upon entering his room MA #1 stated "are you still on the bed pan" Resident #150 indicated that he was still on the bed pan. MA #1 proceeded to apologize to Resident #150 and stated she would remove him from the bed pan and went to gather her supplies. Resident #150 stated he had been	F 550	F550-Resident Rights/Exercise of Rights Criteria 1- The plan of correcting cited deficiency of F550 and the processes that lead to the citation; The facility will treat each resident with respect and dignity 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 plan for correcting the cited deficiency is that the facility will promptly meet the residents' toileting needs. The process failure occurred because staff did not respond timely to a residents need for toileting assistance. Criteria 2- The procedure for implementing the plan of correction for F550; • On 6/4/18 staff were re-educated on timely incontinent care by SDC. • A mandatory In-service will be completed between 6/14/18-6/16/18 on Resident Rights for all shifts. • During routine rounds, IDT members will discuss care needs with the residents or representatives to ensure that residents are receiving cares in a timely manner. • Results will be discussed during morning meeting and any negative concerns will be addressed promptly. Criteria 3- The monitoring procedure to ensure that the plan of correction is	

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F 550	Continued From page 2 on the bed pan for a while and had a bowel movement. MA #1 returned to the bedside and asked Resident #150 to roll onto his left side so she could remove the bed pan. Resident #150 rolled onto his left side and MA #1 removed the bed pan and wiped his perineal area. There was an intact indentation of the bed pan on Resident #150's buttock and back area. Resident #150 denied any pain or discomfort from the bed pan and MA #1 disposed of the bed pan and after washing her hands retuned to the bedside to administer an afternoon medication. An interview was conducted with MA #1 on 05/17/18 at 4:50 PM. MA #1 stated that she had instructed the Nursing Assistants (NAs) on 2nd shift to go and remove Resident #150 from the bed pan because he was finished having a bowel movement. MA #1 could not recall the exact time she had asked the NAs to remove Resident #150 from the bed pan but stated it was shortly after they arrived for their shift at 3:00 PM. An interview was conducted with NA #5 on 05/17/18 at 5:03 PM. NA #5 confirmed that she and NA #6 were working the unit where Resident #150 resided on 2nd shift. NA #5 stated that she was not aware that Resident #150 was on the bed pan or that he needed to be taken off the bed pan. NA #5 stated if she had known Resident #150 needed to be removed from the bed pan she would have went and taken him off it. A follow up interview was conducted with Resident #150 on 05/17/18 at 5:54 PM. Resident #150 stated that he was placed on the bed pan at 2:15 PM by the clock on the wall to the right of his bed and was instructed to turn the call light on when he was finished. He added that he had had	F 550	effective and that the deficiency remains corrected and/or in compliance with the regulatory requirements include the following; • The DON or designee will complete weekly audits by interviewing 5 residents or resident representatives per week for 12wks to ensure the plan of correction is effective and remains in compliance with the regulatory requirement. • Results will be reported to monthly QAPI meeting. • The QAPI committee will determine the need for further auditing after the initial 12 weeks. Criteria 4- The person responsible for implementing the plan of correction. The DON is responsible for implementing the corrective action. The date of compliance is 6/16/18	

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F 550	Continued From page 3	F 550		

a bowel movement and was ready to be removed from the bed pan at 3:10 PM and he turned the call light on. He added a staff member who he did not know came into his room. Resident #150 stated that when the staff member came into his room she demanded to know who had put him on the bed pan, she then turned off the call light and exited the room and did not return. Resident #150 stated he talked to his nephew on the phone and eventually fell off to sleep until MA #1 came it at 4:45 and removed him from the bed pan. Resident #150 stated that it really irritated him that he had to wait so long to be removed the bed pan, he stated "it seems like I have to wait for everything around here" "wait to be put on the bed pan, wait to be taken off the bed pan, wait for staff to answer my call light, I spend a lot of time waiting for things to happen." Resident #150 stated he was very reluctant for the staff to remove his indwelling catheter because of all the waiting he must do and how he would manage to use the urinal while in bed.

An interview was conducted with NA #6 on 05/17/18 at 6:01 PM. NA #6 stated that MA #1 had informed her that Resident #150 was on the bed pan and needed to be removed but stated "it was change of shift and I was not sure where I was going to be working and things got crazy and we got busy with other things." NA #6 stated that she went to Resident #150's room at 5:00 PM to remove him from the bed pan but MA #1 had already done so.

An interview was conducted with the Director of Nursing (DON) on 05/19/18 at 9:49 AM. The DON stated that she identified that Resident #150 had some concerns and the bed pan issue was one of them. The DON stated that Resident #150 had

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F 550	Continued From page 4 been placed on the bed pan and had rang his call light to be removed and had to wait awhile. The DON indicated that she had spoken to the staff and instructed them that when a call light was turned on it was her expectation that the care be rendered immediately. She further stated she expected for the staff to report to their assigned unit at the beginning of their shift and immediately began to provide care as needed and if they have questions or concerns doing that they need to reach out to the nurse.	F 550		
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on observations and resident and staff interviews the facility failed to return residents pants and shirts from the laundry after he reported them missing (Resident #89) and failed to provide dignity for a resident who preferred to wear her own personal gowns instead of hospital gowns when her gowns had not been returned from the laundry (Resident #81). 1. Resident #89 was re-admitted to the facility on 03/27/18 with diagnoses which included anemia, high blood pressure, diabetes, high cholesterol and peripheral vascular disease.	F 557	F557-Respect, Dignity/Right to have Personal Property Criteria 1- The plan of correcting cited deficiency of F557 and the processes that lead to the citation; The facility will treat each resident with respect and dignity including ensuring that residents maintain the right to retain and use personal clothing as space permits, unless to do so, would infringe upon the rights or health and safety of other residents. The plan for correcting the	6/16/18

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F 557	Continued From page 5 A review of the admission Minimum Data Set (MDS) dated 04/28/18 indicated Resident #89 was cognitively intact for daily decision making. The MDS also indicated Resident #89 required extensive assistance for bed mobility, transfers, dressing, toileting and hygiene. During an observation and interview on 05/15/18 at 11:19 AM Resident #89 was seated in a wheelchair in his room and was wearing pants and a shirt and shoes. He stated he was missing pants and shirts and they had been missing for 2 weeks. He further stated he had reported his pants and shirts were missing but no one had gotten back to him as to where the items of clothing were. During an interview on 05/18/18 at 3:20 PM, Nurse Aide (NA) #7 stated that the laundry department had been short staffed and residents had complained that their clothes were not being returned to them timely. During an interview in the laundry on 05/19/18 at 9:32 AM with the Laundry Aide (LA) #1 she stated they washed and dried resident's clothing Monday through Thursday when LA #2 worked and was assigned to do residents personal laundry. She stated she was not aware of clothing that had not been returned and stated residents should get their clothing back within a day or two after they were washed and dried. During an observation in the laundry on 05/19/18 at 9:40 AM, NA #3 knocked on the door of the laundry and reported Resident #89 was missing a pair of khaki pants and stated they had been sent to the laundry. LA #1 looked through a rack of	F 557	cited deficiency is that the facility will ensure that clothing is returned to the residents after laundering and that the residents are provided dignity and allowed to wear their personal clothing of choice. The process failure occurred because staff did not return clothes to a resident from laundry after they were reported missing; and failed to assist a resident to wear her own gown, instead of the hospital gown. Criteria 2- The procedure for implementing the plan of correction for F557; • On 6/04/18 laundry staff were re-educated on timely return of laundered clothing. • On 6/14/18 RCS staff were re-educated on allowing residents to wear the preferred choice of clothing • A mandatory In-service to be completed 6/14/18-6/16/18 on Resident Rights for all shifts. • During routine rounds, IDT members will discuss any concerns with the residents or representatives to ensure that residents are receiving care/services that allow them to retain and use their personal possessions. • Results will be discussed during morning meeting and any negative concerns will be addressed promptly. Criteria 3- The monitoring procedure to ensure that the plan of correction is effective and that the deficiency remains corrected and/or in compliance with the regulatory requirements include the following;	

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F 557	Continued From page 6 clothing hanging in the laundry and gave a pair of brown pants to NA #3 and stated that was all the clothing she saw that belonged to Resident #89. During an interview on 05/19/18 at 9:45 AM with the Housekeeping Manager he verified laundry staff did resident's personal laundry from Monday to Thursday each week. He explained residents were expected to put their name inside clothing so they could return it after it was washed and dried. He further explained NAs came to the laundry when residents were missing items of clothing and laundry staff looked to see if the clothing had been hung up in the laundry. He stated it was his expectation for clothing to be returned to residents after they had been washed and dried within 1-2 days. He further stated if clothing was brought to the laundry in the morning it should be returned to the resident by the next morning. During a follow up interview on 05/19/18 at 10:20 AM, Resident #89 stated he received a pair of long brown pants from the laundry this morning but his khaki shorts were still msiing. He further stated his pants and shirts that had been missing for 2 weeks had still not been returned from the laundry. During an interview on 05/19/18 at 11:32 AM the Administrator stated it was her expectation for resident's clothing to be laundered and returned to them in a timely fashion. 2. Resident #81 was admitted to the facility on 07/16/16 with diagnoses that include protein calorie nutrition, contracture of multiple sights, anxiety, hypertension, and depression.	F 557	• The Director of Housekeeping and Laundry or designee will complete weekly audits by interviewing 5 residents or resident representatives per week for 12wks to ensure the plan of correction is effective and remains in compliance with the regulatory requirement. • Results will be reported to monthly QAPI meeting. • The QAPI committee will determine the need for further auditing after the initial 12 weeks. Criteria 4- The person responsible for implementing the plan of correction. The Director of Housekeeping and Laundry Services is responsible for implementing the corrective action. The date of compliance is 6/16/18	

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Review of the most recent quarterly Minimum Data Set (MDS) dated 04/20/18 revealed that Resident #81 was cognitively intact and required extensive assistance of one staff member with dressing.

An observation and interview was conducted with Resident #81 on 05/16/18 at 11:21 AM. Resident #81 was resting in bed with her eyes open and was dressed in a facility hospital gown. Resident #81 stated "I hate these hospital gowns I have 12 of my personal gown that are so pretty but they have been missing for weeks." She added that the hospital gowns were so ugly and my gowns were so colorful and pretty. An observation of Resident #81's closet revealed no personal gowns.

An observation and interview was conducted with Resident #81 on 05/17/18 at 12:00 PM. Resident #81 was resting in bed with eyes open and was dressed in a facility hospital gown. Resident #81 stated "they finally brought some of my gowns back to me." An observation of her closet revealed 7 very colorful flower gowns. Resident #81 stated she hoped they would put one of her personal gown on her today sometime.

An observation of Resident #81 was made on 05/17/18 at 3:31 PM. Resident #81 was resting in bed with her eyes closed. She was dressed in a pink and yellow flowered gown.

An interview was conducted with Nursing Assistant (NA) #8 on 05/18/18 at 2:01 PM. NA #8 confirmed that she had cared for Resident #81 on 05/16/18 and 05/17/18 and had assisted her with dressing. NA #8 stated that Resident #81 liked her personal colorful gowns instead of the

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hospital gowns. NA #8 stated that Resident #81 reported she had sent her gowns to the laundry and they had not returned them and that was why she had to put a hospital gown on her.

An interview was conducted with NA #7 on 05/18/18 at 3:20 PM. NA #7 confirmed that she routinely cared for Resident #81 and was familiar with her needs. NA #7 stated that Resident #81 preferred to be placed in her pretty colorful gowns but they had not been returned from the laundry so she had to place Resident #81 in a hospital gown. NA #7 stated that the laundry department had been short staffed and residents were complaining that their clothes were not being returned to them timely.

During an interview on 05/19/18 at 9:45 AM with the Housekeeping Manager he verified laundry staff did resident's personal laundry from Monday to Thursday each week. He explained residents were expected to put their name inside clothing so they could return it after it was washed and dried. He stated NAs came to the laundry when residents were missing items of clothing and laundry staff looked to see if the clothing had been hung up in the laundry. He stated it was his expectation for clothing to be returned to residents after they had been washed and dried within 1-2 days. He further stated if clothing was brought to the laundry in the morning it should be returned to the resident by the next morning.

An interview was conducted with the Director of Nursing (DON) on 05/19/18 at 10:54 AM. The DON stated that she expected the staff to treat the residents with respect and dignity and if Resident #81 preferred her own gowns then she expected the staff to make sure she had them

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F 557	Continued From page 9 available to her. The DON stated she would add that to her plan of care so that all staff were aware. During an interview on 05/19/18 at 11:32 AM the Administrator stated it was her expectation for resident's clothing to be laundered and returned to them in a timely fashion.	F 557		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each	F 584		6/16/18

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F 584	Continued From page 10 resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to label and store resident's personal items off the floor in the bathrooms on 1 of 4 resident hallways (room #228, #227 and #231). The facility also failed to clean the floors prior to the breakfast meal in 2 of 2 dining rooms (dementia unit and main dining room). The facility further failed to repair missing flooring on a resident hallway (100 hall), failed to clean stains from flooring across from the 100 hall nurse's station and in a resident room (#142) on 1 of 4 resident hallways. The facility also failed to repair a broken toilet paper holder in a resident bathroom (#229), failed to repair cracked caulking with brown stains at the base of toilets in resident bathrooms (#227, #228 and #231), failed to remove a black substance from the floor and caulk around the sink in a resident bathroom (#227) and failed to replace a toilet tank lid with the correct size and repair a cover to the drain line to the toilet in a resident bathroom (#231) on 1 of 4 resident hallways. Findings included:	F 584	F584-Safe/Clean/Comfortable/Homelike Environment Criteria 1- The plan of correcting cited deficiency of F584 and the processes that lead to the citation; The facility will respect each residents right to a safe, clean, comfortable and homelike environment including clean and safe floors, clean, safe and functional bathrooms, properly stored wash basins and bed pans and properly labeled personal items. The plan for correcting the cited deficiency is that the facility will ensure that personal items will be properly stored and labeled, holes in sheet rock will be repaired, bathrooms will be properly cleaned, toilet basins will be re caulked as needed. The process failure occurred because staff did not properly clean resident areas or report maintenance issues. Criteria 2- The procedure for implementing the plan of correction for F584;	

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F 584	Continued From page 11 1. a. Observations on 05/16/18 at 10:53 AM in the bathroom of resident room #228 revealed 1 container of antifungal cream and 1 container of hand cleanser on the back of the sink with no resident names visible on them. Observations also revealed a comb on the top of the toilet tank without a resident name and a box of gloves were on the floor behind the toilet. Observations on 05/17/18 at 3:50 PM in the bathroom of resident room #228 revealed 1 container of antifungal cream and 1 container of hand cleanser on the back of the sink with no resident names visible on them. Observations also revealed a comb on the top of the toilet tank without a resident name and a box of gloves were on the floor behind the toilet. Observations on 05/18/18 at 2:38 PM in the bathroom of resident room #228 revealed 1 container of antifungal cream and 1 container of hand cleanser on the back of the sink with no resident names visible on them. Observations also revealed a comb on the top of the toilet tank without a resident name and a box of gloves were on the floor behind the toilet. Observations on 05/19/18 at 10:02 AM in the bathroom of resident room #228 revealed 1 container of antifungal cream and 1 container of hand cleanser on the back of the sink with no resident names visible on them. Observations also revealed a comb on the top of the toilet tank without a resident name and a box of gloves were on the floor behind the toilet. b. Observations on 05/16/18 at 10:55 AM in the bathroom of resident room #227 revealed a bed pan on the floor uncovered.	F 584	• On 6/08/18 Housekeeping staff were re-educated on how to properly clean resident bathrooms and all floors. • On 6/14/18 Maintenance Staff was in serviced on repairing holes in sheet rock, toilet paper holder repairs, paper towel holder repairs, towel holder repairs, caulking toilet bases, using the proper tank tops on the back of toilets. • On 6/14/18-6/16/18 RCS staff will be re-educated on how to fill out an maintenance request, labeling resident personal items and properly storing resident washbasins and bed pans and personal items. • A mandatory In-service is scheduled on 6/14/18-6/16/18 on Resident Rights for all shifts. • During routine rounds, IDT members will discuss any concerns with the residents or representatives to ensure that residents are receiving care/services that allow them to retain and use their personal possessions. • Results will be discussed during morning meeting and any negative concerns will be addressed promptly. Criteria 3- The monitoring procedure to ensure that the plan of correction is effective and that the deficiency remains corrected and/or in compliance with the regulatory requirements include the following; • The Director of Housekeeping and Laundry or designee, the DON or her designee, the Director of Maintenance or his designee and the Administrator or her designee will complete weekly audits by	

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F 584	Continued From page 12 Observations on 05/17/18 at 3:52 PM in the bathroom of resident room #227 revealed a bed pan on the floor uncovered. Observations on 05/18/18 at 2:42 PM in the bathroom of resident room #227 revealed a bed pan on the floor uncovered. Observations on 05/19/18 at 10:05 AM in the bathroom of resident room #227 revealed a bed pan on the floor uncovered. c. Observations on 05/16/18 at 10:58 AM in the bathroom of resident room #231 revealed a bath basin on the floor uncovered with 2 bottles of body wash inside and the bottles were not labeled with the resident's name. Observations on 05/17/18 at 3:55 PM in the bathroom of resident room #231 revealed a bath basin was on the floor uncovered with 2 bottles of body wash inside and the bottles were not labeled with the resident's name. Observations on 05/18/18 at 2:45 PM in the bathroom of resident room #231 revealed a bath basin was on the floor uncovered with 2 bottles of body wash inside and the bottles were not labeled with the resident's name. Observations on 05/19/18 at 10:07 AM in the bathroom of resident room #231 revealed a bath basin was on the floor uncovered with 2 bottles of body wash inside and the bottles were not labeled with the resident's name. During an interview on 05/19/18 at 10:10 AM, Nursing Assistant (NA) #3 explained bedpans and	F 584	interviewing 5 residents or resident representatives per week for 12wks to ensure the plan of correction is effective and remains in compliance with the regulatory requirement. • Results will be reported to monthly QAPI meeting. • The QAPI committee will determine the need for further auditing after the initial 12 weeks. Criteria 4- The person responsible for implementing the plan of correction. The Director of Housekeeping and Laundry Services, Director of Nursing, Director of Maintenance and Administrator are responsible for implementing the corrective action. The date of compliance is 6/16/18	

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bath basins were supposed to be stored in plastic bags in the bathroom with the resident's name on them. She also stated resident's personal items were supposed to be labeled with their name and staff were not permitted to store any items on the floor in the bathroom such as bath basins.

During a tour and interview on 05/18/18 at 10:22 AM the Director of Nursing (DON) acknowledged the bed pan on the floor in the bathroom of resident room #227 and stated it should have been stored in a plastic bag off the floor. She also acknowledged the personal items in the bathroom of resident room #228 were not labeled with resident names and should have had their names written on them. She stated the box of gloves on the floor behind the toilet needed to be discarded. The DON further stated the bath basin on the floor in the bathroom of resident room #231 should be discarded and the bottles of body wash should have been labeled with resident names.

2. a. Observations on 05/15/18 at 7:55 AM of the dining room in the dementia unit revealed food crumbs and debris on the floor and meal trays had not been delivered for breakfast.

Observations on 05/17/17 at 7:45 AM in the main dining room revealed food crumbs and debris on the floor and meal trays had not been delivered for breakfast.

Observations on 05/18/18 at 7:46 AM in the dining room in the dementia unit revealed food crumbs on the floor and meal trays had not been delivered for breakfast.

b. Observations on 05/15/18 at 8:15 AM on the

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100 hall across from a therapy office there was a square area of missing flooring in the center of the hallway floor.

Observations on 05/17/17 at 8:45 AM on the 100 hall across from a therapy office there was a square area of missing flooring in the center of the hallway floor.

Observations on 05/18/18 at 9:00 AM on the 100 hall across from a therapy office there was a square area of missing flooring in the center of the hallway floor.

c. Observations on 05/15/18 at 8:17 AM on the 100 hall across from the nurse's station revealed flooring with brownish stains.

Observations on 05/17/17 at 8:52 AM on the 100 hall across from the nurse's station revealed flooring with brownish stains.

Observations on 05/18/18 at 9:12 AM on the 100 hall across from the nurse's station revealed flooring with brownish stains.

d. Observations on 05/15/18 at 8:25 AM there was missing flooring next to access plates to the drain system and the edges of the flooring was jagged and uneven on the 100 hall between the therapy office and the nurses station and between resident room #132 and #134.

Observations on 05/17/17 at 8:52 AM there was missing flooring next to access plates to the drain system and the edges of the flooring was jagged and uneven on the 100 hall between the therapy office and the nurses station and between resident room #132 and #134.

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Observations on 05/18/18 at 9:15 AM there was missing flooring next to access plates to the drain system and the edges of the flooring was jagged and uneven on the 100 hall between the therapy office and the nurses station and between resident room #132 and #134.

e. Observations on 05/17/18 at 4:00 PM in resident room #142 revealed a large red stain on the floor between the heating and cooling unit and the resident's bed.

Observations on 05/18/18 at 2:50 PM in resident room #142 revealed a large red stain on the floor between the heating and cooling unit and the resident's bed.

Observations on 05/19/18 at 9:45 AM in resident room #142 revealed a large red stain on the floor between the heating and cooling unit and the resident's bed.

f. Observations on 05/17/18 at 4:05 PM in bathroom of resident room #229 revealed the toilet paper holder was broken and a roll of toilet paper was on top of the toilet tank.

Observations on 05/18/18 at 2:52 PM in bathroom of resident room #229 revealed the toilet paper holder was broken and a roll of toilet paper was on top of the toilet tank.

Observations on 05/19/18 at 9:47 AM in bathroom of resident room #229 revealed the toilet paper holder was broken and a roll of toilet paper was on top of the toilet tank.

g. Observations on 05/16/18 at 10:55 AM in the

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bathroom of resident room #227 revealed brown stains at the base of the toilet and an odor of stale urine.

Observations on 05/17/18 at 3:52 PM in the bathroom of resident room #227 revealed brown stains at the base of the toilet and an odor of stale urine.

Observations on 05/18/18 at 2:42 PM in the bathroom of resident room #227 revealed brown stains at the base of the toilet and an odor of stale urine.

Observations on 05/19/18 at 10:05 AM in the bathroom of resident room #227 revealed brown stains at the base of the toilet and an odor of stale urine.

h. Observations on 05/16/18 at 10:53 AM in the bathroom of resident room #228 revealed a black substance splattered on the floor under the sink and brown stains around the base of toilet and the caulking was missing between the back of the sink and the sheetrock.

Observations on 05/17/18 at 3:50 PM in the bathroom of resident room #228 revealed a black substance splattered on the floor under the sink and brown stains around the base of toilet and the caulking was missing between the back of the sink and the sheetrock.

Observations on 05/18/18 at 2:38 PM in the bathroom of resident room #228 revealed a black substance splattered on the floor under the sink and brown stains around the base of toilet and the caulking was missing between the back of the sink and the sheetrock.

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Observations on 05/19/18 at 10:02 AM in the bathroom of resident room #228 revealed a black substance splattered on the floor under the sink and brown stains around the base of toilet and the caulking was missing between the back of the sink and the sheetrock.

i. Observations on 05/16/18 at 10:58 AM in the bathroom of resident room #231 revealed the lid on the toilet tank was too small with gaps at the front left and right corners. Further observations revealed brown stains around the base of the toilet and a cover for the water supply line to the toilet had pulled away from the wall which exposed a hole in the sheetrock.

Observations on 05/17/18 at 3:55 PM in the bathroom of resident room #231 revealed the lid on the toilet tank was too small with gaps at the front left and right corners. Further observations revealed brown stains around the base of the toilet and a cover for the water supply line to the toilet had pulled away from the wall which exposed a hole in the sheetrock.

Observations on 05/18/18 at 2:45 PM in the bathroom of resident room #231 revealed the lid on the toilet tank was too small with gaps at the front left and right corners. Further observations revealed brown stains around the base of the toilet and a cover for the water supply line to the toilet had pulled away from the wall which exposed a hole in the sheetrock.

Observations on 05/19/18 at 10:07 AM in the bathroom of resident room #231 revealed the lid on the toilet tank was too small with gaps at the front left and right corners. Further observations

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revealed brown stains around the base of the toilet and a cover for the water supply line to the toilet had pulled away from the wall which exposed a hole in the sheetrock.

During a tour and interview on 05/19/18 at 10:30 AM, the Housekeeping Supervisor stated housekeeping staff were expected to clean resident rooms and common areas on a daily basis and they followed a cleaning schedule. He acknowledged the dark stains on the bathroom floor of resident room #228 and stated it looked like splattered paint but was not sure where it had come from. He stated he tried to scrape it but had not tried any other methods to remove it. He explained the bathroom of resident room #231 had to be cleaned frequently and verified the grout around the base of the toilet was stained. He also verified the grout around the base of the toilet in the bathroom of resident room #227 was stained. He stated it was his expectation when housekeepers saw stains around toilets in resident bathrooms to let him know and it was a matter of figuring out what worked and they had to stay on top of it to keep it clean.

During a follow up interview on 05/19/18 at 10:48 AM, the Housekeeping Supervisor stated he was not aware of the stain on the floor in resident room #142. He stated the red stain could be rust or something else and it should have been reported to him. He further stated they would have to strip the wax off the floor to try and remove it. He explained he had tried to clean the floor in front of the 100 hall nurse's station but they would probably have to strip the wax to clean it.

During a tour and interview on 05/19/18 at 10:58

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AM, the Maintenance Director explained they had a work order system and the papers to complete a work order were kept in a notebook at each nurse's station. He stated his assistant checked the notebooks each morning when he made rounds and they prioritized the work that needed to be done. He explained he and his assistant were available 24 hour a day 7 days a week and he expected for staff to report anything that needed repair. He stated he encouraged staff to fill out a work order even if they reported it verbally to him or his assistant to prevent from missing things that needed repair. During the tour he further stated they tried to keep up with caulking around the base of toilets but he expected for housekeeping to let him know when there were brown stains or the caulking had cracked. He confirmed in the bathroom of resident room #229 the toilet paper hanger was broken and he would have expected for housekeeping staff to have reported it. He stated the lid on the toilet tank in the bathroom of resident room #231 had been replaced with the wrong size and the cover over the drain line behind the toilet needed to be replaced. He explained he was not aware of the red stains on the floor in resident room #142 but that was something he would have expected for staff to report. He stated the sink had been repaired in the bathroom of #227 but the caulking had not been replaced after the repair was made. He also confirmed the missing flooring on the 100 hall across from the therapy office and around the access plates to the drain system needed to be repaired to prevent uneven surfaces.

During an interview on 05/19/18 at 11:13 AM, the Administrator stated it was her expectation when maintenance staff was asked to repair something

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F 584	Continued From page 20 they repaired it immediately. She further stated it was her expectation for the building to be kept clean by housekeeping staff and if a mess happened she expected for them to take care of it immediately.	F 584		
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 record review and staff interviews the facility failed to accurately code the reason for discharge on the minimum data set for 1 of 1 residents (Resident #101) that were discharged. The findings Included: Resident #101 was admitted to the facility on 02/07/18 with a subsequent discharge on 03/06/18 with diagnoses that included: Other specified fracture of left pubis, non-displaced fracture of left fibula, fracture of part of left clavicle, abnormalities of gait and mobility, muscle weakness and others. A review of Resident #101's most recent comprehensive Minimum Data Set (MDS) dated 3/6/18 and coded as a discharge assessment revealed Resident #101 was coded as discharging to a psychiatric hospital. A review of Resident #101's electronic progress notes revealed a noted dated 3/6/18 at 10:34 AM that read "Resident discharged to home with home Health. Resident left facility with family	F 641	F641-Accurancy of Assessments Criteria 1- The plan of correcting cited deficiency of F 641 and the processes that lead to the citation; The facility will accurately reflect discharge status of residents on the MDS. The plan for correcting the cited deficiency is that the facility will ensure that discharge status of residents will be accurately coded on the MDS. The process failure occurred because staff pushed the wrong button on the computer. Criteria 2- The procedure for implementing the plan of correction for F 641; • On 6/06/18 MDS Staff was re-in serviced on MDS accuracy related to discharge to the community. • The RCMD or designee will monitor resident discharge records to the community for accuracy. • Results will be discussed during	6/16/18

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F 641	Continued From page 21 member in private vehicle, all prescriptions and discharg paperwork were given to resident. Resident left in no acute distress" An interview with MDS Nurse #1 on 5/18/18 at 4:01 PM revealed the discharge to a psychiatric facility was coded in error. She reported according to the progress note in Resident #101's electronic progress notes, Resident #101 should have been coded as having discharged to the community. She was unable to provide an explanation on why Resident #101 was coded as being discharged to a psychiatric facility. During an interview with the Director of Nursing on 05/19/18 at 10:56 AM she reported it was her expectation that MDS's be coded correctly for the reason of resident discharge.	F 641	morning meeting and any negative concerns will be addressed promptly. Criteria 3- The monitoring procedure to ensure that the plan of correction is effective and that the deficiency remains corrected and/or in compliance with the regulatory requirements include the following; • The RCMD or designee will complete weekly audits of MDS discharge status by reviewing all discharged residents' records for 12wks to ensure the plan of correction is effective and remains in compliance with the regulatory requirement. • Results will be reported to monthly QAPI meeting. • The QAPI committee will determine the need for further auditing after the initial 12 weeks. Criteria 4- The person responsible for implementing the plan of correction. RCMD is responsible for implementing the corrective action. The date of compliance is 6/16/18	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(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 observations, record reviews, resident and staff interviews, the facility failed to provide incontinence care prior to a resident (Resident #82) wetting through her clothing and failed to	F 677	F677-ADL Care Provided for Dependent Residents Criteria 1- The plan of correcting cited deficiency of F677 and the processes that	6/16/18

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F 677	Continued From page 22 remove a resident (Resident #150) from the bed pan for an extended period of time for 2 of 5 residents reviewed for activities of daily living. The findings included: 1. Resident #82 was admitted to the facility on 09/24/15 with diagnoses which included: multiple sclerosis, dementia, anxiety disorder, and major depressive disorder. A review of a quarterly Minimum Data Set (MDS) dated 04/22/18 revealed she was moderately impaired for daily decision making and required extensive assistance of 1 person with toileting. The MDS also revealed she was frequently incontinent of urine and occasionally incontinent of stool. A review of Resident #82's urinary incontinence CAA dated 10/11/17 revealed she was frequently incontinent of urine but would often ask to go to the bathroom and was able to toilet with extensive assistance of 1 person. Resident #82 wore adult briefs because she was often confused and was unable to communicate her need to toilet and was unable to get to the toilet on time and would have incontinent episodes. A review of Resident #82's care plan date 05/03/18 revealed she had a care plan for ADL self-care performance deficit related to her musculoskeletal impairment, multiple sclerosis, and confusion. The goal was for Resident #82 to maintain her current level of function through the review date. Interventions included providing toileting with extensive assistance of 1 person, encourage active participation in tasks and provide cuing with tasks as needed. An observation of Resident #82 on 05/15/18	F 677	lead to the citation; For residents who are unable to carry out ADL, the facility will provide necessary services to maintain good nutrition, grooming, and personal and oral hygiene. The plan for correcting the cited deficiency is that the facility will ensure that toileting assistance and or incontinent care is provided timely. The process failure occurred because staff did not provide timely toileting assistance. Criteria 2- The procedure for implementing the plan of correction for F677; • On 6/14/18-6/16/18 the facility Certified Nursing Assistants and the agency Certified Nursing Assistants were re-educated on the requirement of timely assistance for toileting needs. • New facility and new agency Certified Nursing Assistants will also be in serviced during orientation. • A mandatory In-service is scheduled on 6/13/18 for RCS staff on the need to provide ADL care to those who are unable to carry out ADL in order to promote good nutrition, grooming, and personal and oral hygiene • During routine rounds, staff will address the needs that residents may have with completing ADL care. • During routine rounds, IDT members will discuss care needs with the residents or representatives to ensure that residents are receiving cares in a timely manner. • Results will be discussed during morning meeting and any negative	

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F 677	Continued From page 23 revealed her sitting in the hallway in her wheelchair with a large round wet spot on her right upper thigh area of her pants. Nurse Aide (NA) #4 stated the resident had spilled orange juice on her pants at breakfast. The wound care nurse stated she needed to be changed and rolled her in her wheelchair back to her room for her and NA #4 to change her pants. The wound care nurse and NA #4 were not sure how Resident #82 transferred so NA #4 went to find her NA for the day. NA #2 returned to the room and assisted Resident #82 to bed to change her brief. As NA #2 was transferring Resident #82 her pants were observed to be saturated in urine and the seat of her wheelchair was observed to be wet. NA #2 stated the resident had spilled orange juice on her pants at breakfast and now was wet also. Resident #82 stated "yes, the wetness is cool." Her brief was observed to be saturated with urine and there was an odor of urine. The layers of the brief had separated and the urine had settled in the bottom of the brief and the brief made a thud when thrown into the trash can. The resident was cleaned using aseptic technique by NA #2 and a new brief was applied and clean pants were put on the resident. Resident #82 was assisted back to her wheelchair and she proceeded in her wheelchair out of the room into the hallway. An observation on 05/17/18 at 10:03 AM revealed NA #1 and NA #4 toileted Resident #82 and resident was able to use the bathroom and also had a bowel movement. NA #1 assisted Resident #82 with getting cleaned up and she was assisted off the toilet into her wheelchair. An observation on 05/18/18 at 2:36 PM of Resident #82 revealed her rolling around in the	F 677	concerns will be addressed promptly. Criteria 3- The monitoring procedure to ensure that the plan of correction is effective and that the deficiency remains corrected and/or in compliance with the regulatory requirements include the following; • The DON or designee will complete weekly audits by interviewing 5 residents or resident representatives per week for 12wks to ensure the plan of correction is effective and remains in compliance with the regulatory requirement. • Results will be reported to the QAPI committee monthly. • The QAPI committee will determine the need for further auditing after the initial 12 weeks. Criteria 4- The person responsible for implementing the plan of correction. The DON is responsible for implementing the corrective action. The date of compliance is 6/16/18	

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hallway and her clothing was observed to be dry.

An interview on 05/18/18 at 3:17 PM with NA #1 stated Resident #82 was sometimes able to tell her when she needed to go to the bathroom. NA #1 stated other times if she noticed Resident #82 was squirming in her chair then she probably needed to go to the bathroom. NA #1 stated everyone should try to take Resident #82 to the bathroom to toilet her instead of letting her wet her brief. NA #1 stated sometimes if you didn't get to her right away she might use her brief but she should be taken to the bathroom to toilet. NA #1 stated she had received a call from NA #2 on 05/15/18 and she had told NA #1 she had messed up and Resident #82 had wet through her brief to her pants.

A phone interview was conducted on 05/19/18 at 12:30 PM with NA#2 and revealed she had taken care of Resident #82 on 05/15/18 and she was not on her usual assignment that day. NA #2 stated she had taken Resident #82 to the bathroom on 05/15/18 at 7:15 AM or 7:20 AM and had not felt like Resident #82 urinated a whole lot that morning. NA #2 stated the next time she toileted Resident #82 was at 11:37 AM. NA #2 stated she was not sure if Resident #82 typically wet as much as she had on that day.

An observation on 05/19/18 at 9:13 AM revealed Resident #82 sitting in her wheelchair in the 300/400 hall dining room watching a movie with two other residents. Resident #82's clothing was observed to be dry.

An interview on 05/19/18 at 9:22 AM with NA #3 revealed Resident #82 had been up when she came in to work and NA #3 stated she was

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getting ready to toilet the resident. NA #3 stated she was able to toilet Resident #82 by guiding her with her hands and where to place them as she was sitting on the toilet and getting up off the toilet. NA #3 stated she had always tried toileting her first before letting her use her brief and Resident #82 had done well for her.

An observation on 05/19/18 at 9:38 AM revealed Resident #82 had been toileted and returned to the dining room to watch TV.

An interview on 05/19/18 at 1:06 PM with the Director of Nursing (DON) revealed she would expect if a resident's pants were wet from a spill at breakfast that they be changed and would expect a resident to be changed before wetting through their clothing.

An interview on 05/19/18 at 2:36 PM with the Administrator revealed she would expect if a resident's pants were wet for the resident to be changed.

2. Resident #150 was admitted to the facility on 05/04/18 with diagnoses that included acquired deformity of foot, osteomyelitis, heart failure, peripheral vascular disease, neurogenic bladder, and diabetes mellitus.

Review of a comprehensive Minimum Data Set (MDS) dated 05/11/18 revealed that Resident #150 was cognitively intact and required extensive assistance of 2 staff members with toileting and transfers. The MDS indicated that Resident #150 had impaired vision with no corrective lenses.

An observation and interview was conducted with

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Resident #150 on 05/17/18 at 4:41 PM. Medication Aide (MA) #1 had prepared his medication and entered Resident #150's room. Upon entering his room MA #1 stated "are you still on the bed pan" Resident #150 indicated that he was still on the bed pan. MA #1 proceeded to apologize to Resident #150 and stated she would remove him from the bed pan and went to gather her supplies. Resident #150 stated he had been on the bed pan for a while and had a bowel movement. MA #1 returned to the bedside and asked Resident #150 to roll onto his left side so she could remove the bed pan. Resident #150 rolled onto his left side and MA #1 removed the bed pan and wiped his perineal area. There was an intact indentation of the bed pan on Resident #150's buttock and back area. Resident #150 denied any pain or discomfort from the bed pan and MA #1 disposed of the bed pan and after washing her hands retuned to the bedside to administer an afternoon medication.

An interview was conducted with MA #1 on 05/17/18 at 4:50 PM. MA #1 stated that she had instructed the Nursing Assistants (NAs) on 2nd shift to go and remove Resident #150 from the bed pan because he was finished having a bowel movement. MA #1 could not recall the exact time she had asked the NAs to remove Resident #150 from the bed pan but stated it was shortly after they arrived for their shift at 3:00 PM.

An interview was conducted with NA #5 on 05/17/18 at 5:03 PM. NA #5 confirmed that she and NA #6 were working the unit where Resident #150 resided. NA #5 stated that she was not aware that Resident #150 was on the bed pan or that he needed to be taken off the bed pan. NA #5 stated if she had known Resident #150

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needed to be removed from the bed pan she would have went and taken him off it.

A follow up interview was conducted with Resident #150 on 05/17/18 at 5:54 PM. Resident #150 stated that he was placed on the bed pan at 2:15 PM by the clock on the wall to the right of his bed and was instructed to turn the call light on when he was finished. He added that he had had a bowel movement and was ready to be removed from the bed pan at 3:10 PM and he turned the call light on. He added a staff member who he did not know came into his room. Resident #150 stated that when the staff member came into his room she demanded to know who had put him on the bed pan, she then turned off the call light and exited the room and did not return. Resident #150 stated he talked to his nephew on the phone and eventually fell off to sleep until MA #1 came it at 4:45 PM and removed him from the bed pan.

An interview was conducted with NA #6 on 05/17/18 at 6:01 PM. NA #6 stated that MA #1 had informed her that Resident #150 was on the bed pan and needed to be removed but stated "it was change of shift and I was not sure where I was going to be working and things got crazy and we got busy with other things." NA #6 stated that she went to Resident #150's room at 5:00 PM to remove him from the bed pan but MA #1 had already done so.

An interview was conducted with the Director of Nursing (DON) on 05/19/18 at 9:49 AM. The DON stated that she identified that Resident #150 had some concerns and the bed pan issue was one of them. The DON stated that Resident #150 had been placed on the bed pan and had rang his call light to be removed and had to wait awhile. The

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F 677	Continued From page 28 DON indicated that she had spoken to the staff and instructed them that when a call light was turned on it was her expectation that the care be rendered immediately. She further stated she expected for the staff to report to their assigned unit at the beginning of their shift and immediately began to provide care as needed and if they have questions or concerns doing that they need to reach out to the nurse.	F 677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, resident, staff, and medical doctor interviews the facility failed to provide adequate supervision and implement interventions to prevent a cognitively impaired resident (Resident #300) from attempting to choke an alert and oriented resident (Resident #63) for 1 of 6 residents sampled for supervision to prevent accidents. The findings included: Resident #300 was admitted to the facility on 07/12/16 and readmitted to the facility on 11/10/17 and discharged from the facility on 11/15/17. Resident #300's diagnosis included dementia without behavioral disturbances, major	F 689	F689-Free of Accidents Hazards/Supervision/Devices Criteria 1- The plan of correcting cited deficiency of F689 and the processes that lead to the citation; The facility will provide necessary services to ensure resident safety. The plan for correcting the cited deficiency is that the facility will ensure residents are free from threats of physical violence from other residents. The process failure occurred because the resident felt that his roommate was threatening him. Criteria 2- The procedure for	6/16/18

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F 689	Continued From page 29 depressive disorder, anxiety, and others. Review of a psychiatric evaluation dated 08/10/17 read in part, Resident #300 was being seen for a follow up with a known history of depression and anxiety. Staff reported that Resident #300 had been experiencing increased irritability with verbal aggression. Staff reported Resident #300 got into physical altercation with another resident where he went after the resident and hit him. Resident #300 reported feeling increased irritable, aggravated, and having anxiety. Review of a care plan that was revised on 08/16/17 read in part, Resident #300 has the potential to be physically and verbally aggressive toward other residents. 08/10/17: resident to resident incident without injury. 08/16/17: resident to resident incident without injury. The goal of the care plan read, Resident #300 would demonstrate effective coping and communication skills through the review date. The interventions of the care plan read, monitor frequently (08/10/17), psychological evaluation when available (08/16/18), administer medications as ordered, provide physical and verbal cues to alleviate anxiety, and when he becomes agitated intervene before agitation escalates. Review of a concern form dated 10/27/17 read in part, Resident #300 was standing up on 200-hall from his wheelchair threatening to punch Resident #63. Resident #300 required assistance from 3 staff members to get him to sit down. The form was not signed by any staff member. Review of the most recent quarterly Minimum Data Set (MDS) dated 11/06/17 indicated that Resident #300 was cognitively impaired and	F 689	implementing the plan of correction for F689; " On 5/15/18-6/16/18 all staff were re-educated on abuse policies, procedures and reporting. " A mandatory In-service is scheduled 6/14/18-6/16/18 on Resident Rights for all shifts. " 24 hour reports and incident reports will also be reviewed in clinical meeting and staff will address resident to resident issues. " During routine rounds, staff will address resident to resident issues. " Results will be discussed during morning meeting and any negative concerns will be addressed promptly. Criteria 3- The monitoring procedure to ensure that the plan of correction is effective and that the deficiency remains corrected and/or in compliance with the regulatory requirements include the following; " The DON or designee and/or Administrator or designee will complete weekly audits by interviewing 5 residents or resident representatives per week for 12wks to ensure the plan of correction is effective and remains in compliance with the regulatory requirement. " Results will be reported to the QAPI committee monthly. " The QAPI committee will determine the need for further auditing after the initial 12 weeks. Criteria 4- The person responsible for implementing the plan of correction. The Administrator is responsible for	

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required minimal assistance of one staff member for activities of daily living. No behaviors were noted on the MDS.

Review of a nurses note dated 11/08/17 at 11:18 AM read, Resident #300 transported to the hospital today related to increased aggression, choking, and communicating a threat to his roommate (Resident #63). Signed by Nurse #7.

Review of the police report dated 11/08/17 at 10:47 AM revealed that the police responded to the facility for a report of assault on a handicapped person. A statement that was attached to the police report and dated 11/08/17 from MDS Nurse #2 read, around 10:30 AM a code red (fire code) was called and all staff including myself went to the hallways to secure the residents. MDS Nurse #2 looked into room 202 and saw Resident #300 standing beside Resident #63 yelling at him attempting to hurt him and put his hands around his neck. MDS Nurse #2 did not see Resident #300's hand around Resident #63's neck but his hands were reaching for Resident #63's neck. Resident #63 used his hands to move Resident #300's hands away from his neck. Staff intervened and after 1 minute managed to de-escalate Resident #300 and remove him from the room. The statement was signed by MDS Nurse #2.

Review of the hospital discharge summary dated 11/10/17 indicated that Resident #300 admitted with agitation and aggressive behaviors. Resident #300 stated he had been experiencing increased agitation and on the day of admission (11/08/17) he had a fight with his roommate. Resident #300 denied that he choked Resident #63 and acknowledged that Resident #63 was a

implementing the corrective action.
The date of compliance is 6/16/18

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paraplegic and not in any position to cause any significant damage to him.

Resident #63 was admitted to the facility on 04/04/17 and most recently readmitted to the facility on 06/02/17. His diagnoses included paraplegia. Review of Resident #63's quarterly MDS dated 10/12/17 revealed that he was cognitively intact and required none to minimal assistance with activities of daily living.

An interview was conducted with MDS Nurse #2 on 05/18/18 at 11:13 AM. MDS Nurse #2 stated that on 11/08/17 she was passing by Resident #300's room and saw him standing over top of Resident #63 with his hands cupped going towards Resident #63's neck area. She stated she went right in and stopped Resident #300 by telling him to put his hands down. She added that Nurse #8 entered the room behind her and together they were able to stop Resident #300 from choking Resident #63. MDS Nurse #2 stated that they removed Resident #300 from the room and took him to an office and called the police and sent him out to the emergency room (ER) for evaluation. She stated that Resident #63 was pushing Resident #300's hand away from his neck area and so they never made it around Resident #63 neck. She added that Resident #63 was not scared of Resident #300 but was angry that the incident had occurred. She added that Resident #300 would get irritated but not to the extent of attempting to choke someone. MDS Nurse #2 stated that she had also reported the incident to the Administrator.

An interview was conducted with the Administrator on 05/18/18 at 12:22 PM. The Administrator stated that on 11/08/17 Resident

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#63 was on his phone talking Spanish loudly and Resident #300 got irritated with it and went over to confront Resident #63 about it. She stated that there was no actual contact made between the residents and Resident #63 was not scared but angry at Resident #300. The Administrator stated that the administrative staff had been in morning meeting and were coming out of the meeting and as MDS Nurse #2 passed by Resident #300's room she saw the incident and went in and stopped it. She added that Resident #300 was removed from the room and taken to an office and the police were called and he was sent to the ER and the 2 were never back together again. She stated that she was not aware of the concern form that was in Resident #300's medical record dated 10/27/17 and that she had offered both residents a room change and neither wanted to move. The Administrator stated that she did not recall the fire alarm sounding that day and added that Resident #300 was a sweet man who spent a lot of his time on the front porch and had no other incidents while in the facility.

An interview was conducted with Restorative Aide (RA) #1 on 05/18/18 at 4:12 PM. RA #1 stated that on 11/08/18 she was going down the hallway because the fire alarm had sounded and saw the commotion coming from Resident #300's room. She stated that when she entered the room MDS Nurse #2 and Nurse #8 were pulling Resident #300 out of the room and Resident #63 began telling me what happened, she stated he was screaming "he was trying to choke me." She stated that they took Resident #300 to an office and called the police and they came and took statements from the staff and Resident #300 went to the Emergency Room (ER). She added that Resident #300 would often get his "feathers

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F 689	Continued From page 33	F 689		

ruffled" and we would have to calm him down but she was not aware of any physically aggressive behaviors he had prior to his incident.

An interview was conducted with Nurse #8 on 05/18/18 at 4:58 PM. Nurse #8 stated that on 11/08/18 she was walking down the hall way and noticed the commotion in Resident #300's room and noticed MDS Nurse #2 was already in the room. She stated she entered the room and saw Resident #300 standing over Resident #63 and was cussing and fussing at him. There were swatting hands in the air and Resident #63 was trying to defend himself and keep Resident #300 from touching him. Nurse #8 stated she did not know what escalated the incident but stated they were able to get Resident #300 to sit down in his wheelchair and took him to an office were the police were called and Resident #300 was sent to the ER for evaluation. Nurse #8 stated she reassured Resident #63 that he would be ok because Resident #300 was going to the hospital. She added that Resident #63 was not scared just angry that the incident had occurred.

Attempts to speak to Nurse #7 on 05/18/18 were unsuccessful.

An interview was conducted with Resident #63 on 05/19/18 at 10:43 AM. Resident #63 stated that approximately 6 months Resident #300 who was his roommate at the time tried to choke him. He stated that MDS Nurse #2 and Nurse #8 had to physically remove Resident #300 from over top of him and take him out of the room. Resident #63 stated that Resident #300 was transported to the hospital and when he came back he was on the other side of the building and he never saw him again. He added that he was not scared of

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F 689	Continued From page 34 Resident #300 because they moved out of his room and to the other side of the building and the staff were watching him very close. He added that the police had come and talked to him about the incident as well and he told them that Resident #300 tried to choke and kill him. An interview was conducted with the Medical Doctor (MD) on 05/19/18 at 2:11 PM. The MD stated that he took over at the facility about 3 weeks ago. The MD stated that the facility was responsible for supervising the resident to make sure they were safe. He added that if residents had aggressive behaviors we check vital signs and make sure there was nothing metabolic or any infection occurring that would cause altered mental status. He stated that most importantly that when a resident was aggressive or had history of being aggressive we must protect the other residents and place the aggressive resident in a private room and rule out any infection or metabolic irregularity. The MD stated that the goal of the situations was to keep the abuser and the other residents as safe as possible. The MD stated that the facility has recently hired additional staff and he believed with the additional staff they were able to adequate supervise the residents.	F 689		
F 711 SS=D	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section;	F 711		6/16/18

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F 711	Continued From page 35 §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to ensure a physician had signed off on a resident's admission orders in a timely fashion for 1 of 2 residents with a catheter (Resident #150). Findings Included: Resident #150 was admitted to the facility on 05/04/18 with diagnoses that included acquired deformity of foot, osteomyelitis, heart failure, peripheral vascular disease, neurogenic bladder, and diabetes mellitus. A review of Resident #150's most recent comprehensive assessment dated 5/17/18 revealed resident to be cognitively intact while needing extensive assistance with all Activities of Daily Living outside of eating (supervision) and bathing (totally dependent). Resident #150 was coded as having an indwelling catheter and was frequently incontinent of bowel. A review of Resident #150's medical record on 05/19/18 at 9:18 AM revealed original admitting physician orders on the chart. Further review revealed no physician signature on the admitting orders to the facility. Additional review of Resident #150's chart revealed additional	F 711	F711-Physicain Visits-Review Care/Notes/Order Criteria 1- The plan of correcting cited deficiency of F 711 and the processes that lead to the citation; The facility will ensure that physician orders are signed per the facility's policy. The plan for correcting the cited deficiency is that the facility will ensure that Physicians Orders will be signed per the facility policy. The process failure occurred because physician orders were not signed per facility policy. Criteria 2- The procedure for implementing the plan of correction for F 711; • On between 5/15/18-6/16/18 Staff was in serviced on timeliness of signed physician orders . • The DON or designee will monitor physician orders for timeliness of signatures. • Results will be discussed during morning meeting and any negative concerns will be addressed promptly. Criteria 3- The monitoring procedure to ensure that the plan of correction is	

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F 711	Continued From page 36 physician orders signed by the physician dated 05/10/18 and 05/14/18. An interview with the Director of Nursing on 05/19/18 at 10:18 AM revealed she had no explanation on why the admitting physician orders had not been signed when there were other orders that had been signed on 05/10/18 and on 05/14/18. She reported she had looked for a signed copy of the admitting physician orders in medical records but was unable to locate a signed version of the admitting orders. She reported the orders must have just been overlooked. She further stated it was her expectation that physician orders that were called in were to be signed the next time the attending physician was in the facility. An interview with the Administrator on 05/19/18 at 12:49 PM revealed it was her expectation that physician orders were signed per the facility's policy.	F 711	effective and that the deficiency remains corrected and/or in compliance with the regulatory requirements include the following; • The DON or designee will complete weekly audits of 5 residents records to ensure timely signature of Physicians Orders for 12wks to ensure the plan of correction is effective and remains in compliance with • Results will be reported to monthly QAPI meeting. • The QAPI committee will determine the need for further auditing after the initial 12 weeks. Criteria 4- The person responsible for implementing the plan of correction. DON is responsible for implementing the corrective action. The date of compliance is 6/16/18	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(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 appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper	F 761		6/16/18

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F 761	Continued From page 37 temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(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. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to keep the medication cart secured (200 hall medication cart), remove expired and discontinued medications from the medication cart and failed to date an opened vial of insulin (200 hall medication cart) for 1 of 3 medication carts observed. The facility also failed to remove an expired medication from a medication room refrigerator that was available for use for 1 of 2 medication rooms observed (100/200 hall medication room). The findings included: Review of a facility policy titled "Storage and Expiration of Medications, Biologicals, Syringes, and Needles "dated 10/31/16 read in part, facility should ensure that all medications and biologicals are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors. The policy further stated, "the facility should ensure that medications and biologicals have an expiration date and have been retained longer than recommended by	F 761	F 761 Label/Store Drugs and Biologicals Criteria 1- The plan of correcting cited deficiency of F761 and the processes that lead to the citation; The facility plan is that all medications and biologicals are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents or visitors. All required medications and biologicals will have an open date or expiration date label on the medication, and that all discontinued or expired medications will be removed from use from the medication cart or refrigerator. The process failure occurred when a staff member walked away from a medication cart without engaging the lock, therefore, leaving the medication cart unlocked. The process failure occurred when staff failed to dispose of an expired medication and when staff failed to date an insulin vial when opened leaving the vial without an expiration date. Criteria 2- The procedure for	

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F 761	Continued From page 38 manufacturer or supplier guidelines." a. An observation of the 200-hall medication cart was made on 05/15/18 at 11:14 AM. The medication cart was parked on the hallway and was not attended by facility staff. The lock on the medication cart was not engaged indicating the medication cart was unlocked. There was staff and residents moving up and down the hallway. Minimum Data Set (MDS) Nurse #1 approached the medication cart and confirmed that the medication cart was unlocked and unattended. MDS Nurse #1 went to alert Nurse #4 that her medication cart was left unlocked and unattended. Nurse #4 returned to the medication cart and engaged the lock. An interview was conducted with Nurse #4 on 05/15/18 at 11:16 AM. Nurse #4 confirmed that she was responsible for the 200-hall medication cart and stated, "I am so sorry I just stepped away for a minute but I should have locked the cart." b. An observation of the 200-hall medication cart was made on 05/16/18 at 3:53 PM. The medication cart was parked on the hallway with residents and staff walking up and down the hallway. The lock on the medication cart was not engaged indicating the medication cart was unlocked and was not supervised by staff. Nurse #5 returned to the medication and confirmed that she had left it unlocked and engaged the lock. An interview was conducted with Nurse #5 on 05/16/18 at 3:55 PM. Nurse #5 stated "I forgot to lock my cart and I am so sorry." She added that anytime her medication cart was not in her view the medication cart should be locked and	F 761	implementing the plan of correction for F761; • On 6/4/18 facility and agency staff were re-educated on Medication Administration in the facility which included expired medications and locking of the med cart. • New facility and agency staff will be in serviced on Medication Administration in the facility including expired medications and locking of med cart during orientation. • Mandatory staff In-Service is scheduled on 6/14/18-6/16/18 on expired medications and locking of the medication cart; including disposing of all expired medications and dating all opened medications. • Unit managers will audit medication carts 3 times a week for 12 weeks for any opened, undated medications and expired medications. • During routine rounds the IDT members will check for unlocked medication carts, correct the situation and report any found to be unlocked and unattended to the DON immediately. Criteria 3- The monitoring procedure to ensure that the plan of correction is effective and that the deficiency remains corrected and/or in compliance with the regulatory requirements include the following; • The DON will review expired medication audits completed by the unit managers every week and follow-up on any trends or patterns. • The DON will report results to the QAPI committee monthly.	

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F 761	Continued From page 39 secured. c. An observation of the 200-hall medication cart was again made on 05/18/18 at 2:43 PM. The observation revealed an opened vial of Humulin insulin (used to treat diabetes) that was not dated as to when it was opened. Further review of the medication cart revealed a card of 30 lorazepam (antianxiety medication) that contained a resident's name and dosing instructions. The lorazepam expired on 01/31/18. An interview was conducted with Nurse #6 on 05/18/18 at 2:50 PM. Nurse #6 stated that the Humulin insulin was good for 28 days after opening but because the vial was not dated she could not say when it expired. She indicated the vial should have been dated when opened and that she would dispose of the vial and open and date a new one. Nurse #6 stated that the lorazepam expired in January 2018 and she had no idea why it was still on the medication cart and available for use but added they should have been removed and returned to the pharmacy. d. An observation of the 100/200 hall medication room was made on 05/19/18 at 9:00 AM. The observation revealed an opened box of Brovana (inhaled medication) that contained a label with the resident's name and dosing instructions in the refrigerator available for use that expired on 02/18. The medication was given to Nurse #5. An interview was conducted with Nurse #5 on 05/19/18 at 9:10 AM. Nurse #5 confirmed that the medication was expired and had been discontinued and should have been pulled from the refrigerator and returned to the pharmacy and she was not sure why this one was still in the	F 761	• The QAPI committee will determine the need for further monitoring after the initial 12 weeks. Criteria 4- The person responsible for implementing the plan of correction. The DON is responsible for implementing the corrective action. The date of compliance is 6/16/18	

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F 761	Continued From page 40 refrigerator and available for use. An interview was conducted with the Director of Nursing (DON) on 05/19/18 at 10:52 AM. The DON stated that each nurse should be checking for expired and discharged medication daily. She added that each time they open an insulin vial they should be dating it. The DON stated that 04/25/18 the pharmacy came and checked the medication carts and removed expired and discontinued medications. The DON also stated that she had an external person come in and go through the medication carts and compare the active orders to the medications that were on the cart and they had pulled a lot of medication from the carts and returned them to the pharmacy. The DON stated that she expected the medication carts to remain locked when in not in use.	F 761		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents	F 809		6/16/18

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F 809	Continued From page 41 who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, resident, and staff interviews the facility failed to provide snacks in 3 of 3 nourishments rooms for residents who required bedtime snacks and residents who wanted snacks during off hours. The findings included: An observation on 05/15/18 at 12:30 PM revealed the nourishment room on the 200 hall had milk and applesauce available in the refrigerator and 4 packs of graham crackers in the drawer. The nourishment room on the 100 hall had milk and thickened liquids in the refrigerator and no snacks available in the cabinet or drawer. The nourishment room on the 300/400 halls had milk in the refrigerator and no snacks in the cabinet or drawer. An observation on 05/16/18 at 4:30 PM revealed the nourishment room on the 200 hall had milk and applesauce available in the refrigerator and 4 packs of graham crackers in the drawer. The nourishment room on the 100 hall had milk and thickened liquids in the refrigerator and no snacks available in the cabinet or drawer. The nourishment room on the 300/400 halls had milk in the refrigerator and no snacks in the cabinet or drawer. A called Resident Council meeting was held on 05/17/18 at 4:15 PM with 6 members that routinely attend the meetings on a monthly basis. The residents, some of whom were diabetics,	F 809	F809-Frequency of Meals/Snacks at Bedtime Criteria 1- The plan of correcting cited deficiency of F 809 and the processes that lead to the citation; The facility will ensure that snacks are available to residents. The plan for correcting the cited deficiency is that the facility will ensure that snacks are available to residents. The process failure occurred because snacks were available in the kitchen but not in the nourishment rooms.. Criteria 2- The procedure for implementing the plan of correction for F 809; • On 5/20/18 Dietary Staff was in serviced on providing snacks to residents in the nourishment rooms . • The Dietary Manager or designee will monitor the nourishment rooms for snacks. • Results will be discussed during morning meeting and any negative concerns will be addressed promptly. Criteria 3- The monitoring procedure to ensure that the plan of correction is effective and that the deficiency remains corrected and/or in compliance with the regulatory requirements include the following; • The Dietary Manager or designee will	

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F 809	Continued From page 42 stated they were not receiving bedtime snacks like they were supposed to nightly. They stated they had been told by the Dietary Manager the only snacks they would be provided would be animal crackers or graham crackers and stated those were sometimes not available. They stated they had not received bedtime snacks and most of them had to keep snacks in their rooms to have something to eat at night. They stated they had not been receiving a half sandwich for their snack on their dinner tray like they were supposed to and no one had come around at night to offer a bedtime snack. An observation on 05/17/18 at 4:53 PM revealed the nourishment room on the 200 hall had milk and applesauce available in the refrigerator and 4 packs of graham crackers in the drawer. The nourishment room on the 100 hall had milk and thickened liquids in the refrigerator and no snacks available in the cabinet or drawer. The nourishment room on the 300/400 halls had milk in the refrigerator and no snacks in the cabinet or drawer. An interview on 05/18/18 at 8:54 AM with the Activities Director (AD) who attends the Resident Council meeting revealed she was aware the residents had requested some fresh fruit options and they had been providing bananas, apples and oranges for the residents. The AD stated there were always cookies and ice cream available in the kitchen and sugar free options for diabetics and they just had to come to the kitchen and ask. The AD stated she was not sure what happened after the kitchen employees left but stated the nurses were probably able to access the kitchen after hours for snacks.	F 809	complete weekly audits of the nourishment rooms for 12wks to ensure the plan of correction is effective and remains in compliance with the regulatory requirement. • Results will be reported to monthly QAPI meeting. • The QAPI committee will determine the need for further auditing after the initial 12 weeks. Criteria 4- The person responsible for implementing the plan of correction. Dietary Manager is responsible for implementing the corrective action. The date of compliance is 6/16/18	

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F 809	Continued From page 43	F 809		

An interview on 05/18/18 at 3:35 PM with Nurse Aide (NA) #7 stated that they had not had snacks often and she had brought snacks in to the residents because they were not available to them from the kitchen.

An interview on 05/18/18 at 3:51 PM with the Dietary Manager (DM) revealed there was a list of snacks the company had agreed upon to have available anytime for residents and stated he tried to keep a good amount available in the nourishment rooms. The DM stated that bedtime snacks for diabetics were a ½ sandwich which was sent out on their dinner tray and there were sandwiches sent out at night on a tray with diabetic resident names on them. The DM stated if they were not diabetic and catch us in the kitchen before we leave in the evening they can get a snack of their choice. The DM stated his staff usually stocked the nourishment rooms every day between 2:00 and 4:00 PM but stated that snacks had not been provided in the nourishment rooms this week. The DM stated snacks had not come in on his order on Monday when the truck came so he re-ordered them to come on Thursday. He stated his order had not come on Thursday's truck, he went to the Administrator and informed her that he had no snacks to put in the nourishment rooms. The DM stated the Administrator had sent staff out to purchase snacks for the nourishment room and they were in there now. The DM stated his expectation was for the nourishment rooms to be stocked daily with milk, a variety of ½ sandwiches and pre-packaged snacks for the residents.

An observation on 05/19/18 at 9:58 AM revealed the 200 hall nourishment was stocked with milk, applesauce, 1/2 sandwiches in the refrigerator

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F 809	Continued From page 44 and a variety of pre-packaged snacks in the drawer. The 100 hall nourishment room had milk and thickened liquids and 1/2 sandwiches in the refrigerator and a variety of pre-packaged snacks in the cabinet. The nourishment room on the 300/400 halls had milk, 1/2 sandwiches and applesauce in the refrigerator and a variety of pre-packaged snacks in the cabinet. An interview on 05/19/18 at 1:03 PM with the Director of Nursing (DON) revealed her expectation was for snacks to be available at all times for all residents in the nourishment rooms. An interview on 05/19/18 at 2:06 PM with the Administrator revealed she felt snacks were available in the kitchen but would expect snacks to be available at all times for all residents in the nourishment rooms.	F 809		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		6/16/18

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F 812	Continued From page 45 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, and staff interviews the facility failed to have expired milk discarded before it was served to a resident (Resident #5) during 1 of 2 meal observations. An observation of the breakfast meal was made on 05/16/18 at 10:55 AM. An observation of Resident #5 revealed she had finished consuming her breakfast tray and the staff had removed the tray from her bedside table but had left her carton of milk for her to finish. The resident had the milk carton in her hand and was slurping the last bit of milk from the carton. The carton was dated 05/08/18 and was given to Nurse #3. An interview was conducted with Nurse #3 on 05/16/18 at 11:05 AM. Nurse #3 confirmed that she was caring for Resident #5 and that she had received the milk carton on her breakfast tray. She stated she had no idea that the milk was expired or she would have taken it from her immediately. An interview was conducted with the Dietary Manager (DM) on 05/18/18 at 10:50 AM. The DM stated he had no idea where the expired milk had come from. He stated that another resident had also received a carton of milk that expired on 05/08/18 and that due to the way the date was stamped on the carton he believed the milk was not a carton from his kitchen but maybe from a convenience store.	F 812	F812-Food Procurement, Store/Prepare/Serve Sanitary Criteria 1- The plan of correcting cited deficiency of F 812 and the processes that lead to the citation; The facility will ensure that milk is within sell by date. The plan for correcting the cited deficiency is that the facility will ensure that milk is within sell by date. The process failure occurred because staff did not ensure that milk was in sell by date. Criteria 2- The procedure for implementing the plan of correction for F 812; • On 5/20/18 Dietary Staff was in serviced on milk sell by date and procedure to ensure no expired milk was left in the facility . • The Dietary Manager or designee will monitor the milk's sell by date daily in the cooler before it gets to the tray line. Any out of date milk will be removed prior to being offered to residents. • Results will be discussed during morning meeting and any negative concerns will be addressed promptly. Criteria 3- The monitoring procedure to ensure that the plan of correction is effective and that the deficiency remains corrected and/or in compliance with the regulatory requirements include the following;	

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F 812	Continued From page 46 A follow up interview was conducted with the DM on 05/18/18 at 12:56 PM. The DM stated that he had a Dietary Aide (DA) that rotated and pulled the expired items every day. He indicated that the DA pulled the expired products every day and that he would return them for monetary credit to the facility. The DM further stated that as he was putting out the snacks for the day he was also reviewing expiration dates. He added that the milk delivery personnel delivered to the facility every Monday and Thursday and he would also check for expired milk. The DM again stated that he believed the milk was coming from a convenience store and had no idea how the expired milk got served to the residents. An interview was conducted with the Director of Nursing (DON) on 05/19/18 at 10:54 AM. The DON stated that she expected expired milk to be discarded before it was served to the residents.	F 812	• The Dietary Manager or designee will complete weekly audits of the milk supply for 12wks to ensure the plan of correction is effective and remains in compliance with the regulatory requirement. • Results will be reported to monthly QAPI meeting. • The QAPI committee will determine the need for further auditing after the initial 12 weeks. Criteria 4- The person responsible for implementing the plan of correction. Dietary Manager is responsible for implementing the corrective action. The date of compliance is 6/16/18	
F 867 SS=E	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 observations, record review, and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions the committee put into place in April of 2017 following a recertification and complaint survey and following a complaint survey in August	F 867	F867 QAPI/QAA Improvement Activities Criteria 1- The plan of correcting cited deficiency of F 867 and the processes that lead to the citation; The facility will ensure that it has an effective QAPI Committee. The plan for	6/16/18

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F 867	Continued From page 47 2017 and Febuary 2018. The repeat deficiencies are in the areas of respect and dignity (F550), Safe/Clean/Comfortable/Homelike Environment (584), Free of Accident Hazards/Supervision (F689), and Food Procurement, Store/Prepare/Serve (F812). These deficiencies were recited during the facility's current recertification survey. The continued failure of the facility during 4 federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The Findings Included: The tags were cross referred to: 1. F550: Based on observation, record review, resident, and staff interviews the facility failed to treat a resident in a dignified manner by not removing the resident from the bed pan for an extended period of time for 1 of 3 residents sampled for incontinence care (Resident #150). During the Recertification survey completed on 03/10/17 the facility failed to promote the dignity for 1 of 4 sampled residents when 2 staff failed to knock on the door and/or announcing staff presence before entering Resident #13's room. 2. F584: Safe/Clean/Comfortable/Homelike Environment. Based on observations and staff interviews the facility failed to label and store resident's personal items off the floor in the bathrooms on 1 of 4 resident hallways (room #228, #227 and #231). The facility also failed to clean the floors prior to the breakfast meal in 2 of 2 dining rooms (dementia unit and main dining room). The facility further failed to repair missing flooring on a resident hallway (100 hall), failed to	F 867	correcting the cited deficiency is that the facility has secured a new Permanent DON, a new Medical Director, a new Director of Housekeeping and Laundry. The process failure occurred because the facility didn't have consistent, seasoned department heads. Criteria 2- The procedure for implementing the plan of correction for F 867; • On 6/15/18 the QAPI Committee will be in serviced on the new QAPI process and expectations . • The Administrator and the Medical Director will monitor the QAPI Process • Results will be discussed during QAPI and morning meeting and any negative concerns will be addressed promptly. Criteria 3- The monitoring procedure to ensure that the plan of correction is effective and that the deficiency remains corrected and/or in compliance with the regulatory requirements include the following; • The Administrator or designee will review weekly audits for F550, F584, F689 and F812 for 12wks to ensure the plan of correction is effective and remains in compliance with the regulatory requirement. • Results will be reported to monthly QAPI meeting. • The QAPI committee will determine the need for further auditing after the initial 12 weeks. Criteria 4- The person responsible for implementing the plan of correction. Administrator is responsible for	

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F 867	Continued From page 48 clean stains from flooring across from the 100 hall nurse's station and in a resident room (#142) on 1 of 4 resident hallways. The facility also failed to repair a broken toilet paper holder in a resident bathroom (#229), failed to repair cracked caulking with brown stains at the base of toilets in resident bathrooms (#227, #228 and #231), failed to remove a black substance from the floor and caulk around the sink in a resident bathroom (#227) and failed to replace a toilet tank lid with the correct size and repair a cover to the drain line to the toilet in a resident bathroom (#231) on 1 of 4 resident hallways. During the Recertification survey completed on 03/10/17 the facility failed to repair a missing call bell cord in 1 of 26 resident bathrooms on the 200 hall (room #232); failed to repair the smoke prevention doors with broken and splintered laminate and wood on the 100 hall, 200 hall and Courtyard Terrace hall; failed to repair the dining room door on the 300 hall with broken and splintered laminate and wood on the lower edges of the door; failed to repair the activity/dining room door on the 400 hall with broken and splintered laminate and wood on the lower edges of the door; failed to repair the activity room door on the main hall with broken and splintered laminate and wood on the lower edges of the door; failed to repair resident room and bathroom doors with broken and splintered laminate and wood in 6 of 23 rooms on the 300 and 400 halls (resident rooms #301, #305, #306, #311, #404 and #405); failed to remove brown stains from sinks drains, overflow drains and faucets in 3 of 13 rooms on the 300 hall (resident bathrooms #301, #305, and #306); failed to repair brown stains around the base of toilets in 2 of 23 rooms on the 300 and 400 hall (resident room #305 and	F 867	implementing the corrective action. The date of compliance is 6/16/18	

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F 867	Continued From page 49	F 867		

#402); failed to repair wall damage in 6 of 23 rooms on the 300 and 400 halls (resident room #306, #310, #401, #402, #405 and #408) and failed to remove debris inside the grate of a heating and air conditioning unit in the 300 hall dining room.

3. F689: Free of Accident Hazards/Supervision. Based on record review, resident, staff, and medical doctor interviews the facility failed to provide adequate supervision and implement interventions to prevent a cognitively impaired resident (Resident #300) from attempting to choke an alert and oriented resident (Resident #63) for 1 of 6 residents sampled for supervision to prevent accidents.

During a complaint investigation completed on 02/28/18 the facility failed to prevent a resident from falling from bed and sustaining injury for 1 of 3 residents sampled for accidents (Resident #1). Resident #1 fell from the bed during incontinent care and sustained a subcutaneous hematoma that required evacuation (removal) and required placement of a wound vacuum.

During a recertification survey completed on 03/10/17 the facility failed to implement planned interventions of bed alarms and positioning a wheelchair out of sight in order to prevent falls for 2 of 4 residents reviewed for falls (Resident #50 and #29).

4. F812: Food Procurement, Store/Prepare/Serve. Based on observation, record reviews, and staff interviews the facility failed to have expired milk discarded before it was served to a resident (Resident #5) during 1

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F 867	Continued From page 50 of 2 meal observations. During a recertification survey completed on 03/10/17 the facility failed to have adequate chemical solution in a 3 compartment sink for sanitizing pots and pans for 1 of 1 three compartment sink; failed to keep a microwave clean and failed to label and date personal items for 3 of 3 nourishment rooms. During an interview on 5/19/18 at 2:08PM the Administrator explained the Quality Assessment and Assurance Committee meetings were conducted on a monthly basis which included the Administrator, Medical Director, Director of Nursing and various department managers. She further explained that the deficiencies identified during the current recertification would be discussed and ongoing monitoring would begin. She reported she would review the final survey report and would determine with the assistance of the Quality Assessment and Assurance Committee the plans that would need to be developed to prevent the deficiencies from reoccurring on additional surveys.	F 867		