STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345552	A. BUILDING _____ B. WING _____	05/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SHANNON GRAY REHABILITATION & RECOVERY CENTER	2005 SHANNON GRAY COURT JAMESTOWN, NC 27282

(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 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review the facility failed to provide side rails for one of two sampled residents who requested the side rails and needed the side rails for bed mobility. (Resident #70). The findings included: Resident #70 was admitted to the facility on 10/7/17 with diagnosis of a neuro-muscular disorder. Review of the Admission Minimum Data Set (MDS) dated 10/20/17 indicated Resident #70 had no long or short- term memory impairment and was cognitively intact. This MDS indicated she required total assistance of one staff member for bed positioning. The MDS indicated the resident did not walk. Review of a form "Side Rail Alternative Intervention Assessment" dated 3/23/18 indicated the resident could not get in and out of the bed independently, did not verbalize concerns regarding the edge of the bed orientation, she had problems with balance and trunk control, required the use of an assistive device for positioning, mobility or support, could not use a	F 558	To correct the deficiency cited, the facility re-assessed resident #70 on 5/23/18 and determined that side rails could be utilized for bed mobility. A root cause analysis determined the facility did not know the resident in question wanted side rails upon their removal as the resident did not state side rails were still desired (following the initial assessment). To correct this issue, the facility utilized the most recent BIMS assessments and interviewed 50 current residents who could provide appropriate feedback for their desire to be considered for side rails. 14 additional residents requested side rails and were assessed using an updated procedure to ensure side rail appropriateness. This was done to acknowledge resident accommodation/needs/preferences. Currently, as of 6/8/18, all residents who have requested side rails either have them safely in place or are having them installed via maintenance once the entire internal QA procedure/process for side rail usage has been completed. The new procedure, which includes documented resident interview, is in place and will continue to ensure compliance in this area.	6/14/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/09/2018

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F 558	Continued From page 1 pull up motion with her upper extremities to reposition herself and was not able to stand. The use of side rails was not an intervention listed for mobility on the form. The intervention checked for use was a bolster mattress. There were no comments in the comment box. The MDS dated 4/5/18, a quarterly, indicated Resident #70 had no long or short- term memory impairment and was cognitively intact. The MDS indicated she required total assistance of two staff members for bed positioning and she did not walk. Review of the care plan updated 4/18/18 included the use of bolster mattress to promote movement and positioning when in bed. Interview with Resident #70 on initial tour on 5/14/18 at 10:45 AM revealed she requested to have her half side rails back on the bed. Further interview revealed she could not use her left hand, but she could use her right hand. She explained she could grab the side rail with her right hand and reposition/turn herself in bed. She then explained, with the foam devices, she had nothing to hold onto. The sheet was smooth, and the foam devices were not elevated to enable her to get a grip for turning in the bed. Further interview revealed she was informed she would have to "sign a form" if she wanted the side rails back on the bed. Observations on 5/14/18 at 10:45 AM revealed Resident #70 had long round foam devices, like pool "noodles" under the bottom sheet on each side of the mattress. Interview with the Director of Nursing (DON) on	F 558	To implement this plan of correction, the facility in-serviced the DON, Unit Coordinators, MDS staff, NHA and other members specific to a revised internal QA process that has been expanded to include a documented resident interview. This new step will ensure the facility can prove that resident preferences have been considered as part of the overall determination of side rail safety/appropriateness. This QA tool (The SR Assessment Resident Interview QA Tool) as part of the side rail assessment process has been completed for all current and appropriate residents (BIMS score 13 or more) and will continue indefinitely with all future admissions. The facility created the 2018 Annual Survey Plan of Correction QA team which includes a minimum of the NHA, DON, COO, Unit Coordinators, MDS staff, Medical Records leader, Dietary Manager and Executive Chef, facility SWs. This team will meet to provide an interdisciplinary approach and can/will expand as necessary to continue with compliance. The QA team will meet weekly for a minimum of 6 months and then monthly thereafter for the reminder of the time until the next annual survey process. Changes and revisions may be necessary and the facility reserves the right to update the plan of correction for the purpose of ensuring ongoing compliance. Any changes in this plan of correction for the purpose of compliance will be addressed in QAPI format. The	

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F 558	Continued From page 2 5/17/18 at 2:08 PM revealed the side rail assessment was completed within the last couple of months. A team approach was used with the DON, Administrator, therapy member, and unit coordinator. Further interview revealed the resident was not asked if she wanted the side rails, but did not voice she wanted side rails during the assessment. The DON explained the bolsters (long round foam devices) were used by the resident when staff turned her in bed. When asked if she could grasp the bolster, and turn independently, she explained the resident could hold onto the bolster as two staff turned the resident. Interview with both MDS nurses on 5/17/18 at 2:39 PM revealed they were not involved in the side rail assessment for Resident #70. Interview with the Unit Manager #1 on 5/17/18 at 3:00 PM revealed the team did the assessment by going through the yes/no questions on the assessment form. Further interview revealed Resident #70 was not able to turn independently without the side rails. During the interview, it was revealed the team tried the bolster and Resident #70 she had not expressed any edge of the bed concerns. Interview with the Chief Operating Officer, the Administrator and the DON on 5/18/18 at 4:00 PM revealed the side rails had been removed because of citations from another team at their sister facility. He indicated they had not asked the resident if she wanted the side rails, or if she could use the side rails. Their assessment included measuring the gap between the mattress and side rails, and using the assessment form. Due to the resident requiring	F 558	DON will ensure that any side rail assessment interviews completed since the previous week's QA team meeting will be reviewed at the current QA team meeting. This QA team met most recently on 6/7/18 and will continue meeting as stated unless otherwise noted. The QA meeting is designed to allow the facility to ensure the newly expanded procedure (which includes a documented resident interview) accommodates resident needs/preferences for side rail usage where safe/appropriate. The D.O.N. will report a summary of the QA interviews (also on total Side Rail usage) at the Executive Quarterly QA meeting. The next scheduled Executive Quarterly QA meeting is scheduled for 7/6/18. The Director of Nursing will be responsible for implementing this portion of the plan of correction. The facility alleges compliance will all aspects of this portion of the plan of correction by 6/14/18.	

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F 558	Continued From page 3 assistance in turning, the side rails were removed.	F 558		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review the facility failed to obtain food likes/dislikes for one of three sampled residents	F 561	To correct the deficiency cited, the facility Dietary Manager interviewed Resident #70 during the survey and likes and	6/15/18

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F 561	Continued From page 4 for food concerns. Resident #70. The findings included: Resident #70 was admitted to the facility on 10/7/17 with a diagnosis of neuromuscular disorder. Review of the "Food Preference Form" dated 10/7/17 that was completed on admission, indicated two preferences: 2 pieces of toast and either hot or cold cereal. There were no dislikes listed. Review of the Admission Minimum Data Set (MDS) dated 10/20/17 indicated Resident #70 had no long or short- term memory impairment and was cognitively intact. Review of a progress note by Certified Dietary Manager (CDM), dated 11/8/17 included Resident #70 was edentulous (had no teeth) had no problems with current diet consistency. She was fed by staff. Her intake varied 75% or greater and her weight BMI (Body Mass Index) was above normal. Resident #70 was on a mechanical soft diet with thin liquids. Review of the meal consumption percentages from 3/1/18 to 4/30/18 revealed Resident #70 averaged 25% of the meals. Review of the most recent care plan dated 4/18/18 included a problem of risk for altered nutrition and had recent significant weight variance, and was above ideal body weight. One of the approaches included for dietary to "Honor food preferences as tolerated."	F 561	dislikes were updated at that time. Note: the resident had a likes and dislikes interview completed on the Food Preference Form on 10/7/17. Instead of completing these only at the time of admission or when residents request changes, the facility changed the internal process of the frequency of interviewing residents for food preferences. This will now be done every 6 months (still upon admission and prn as well) on the Food Preference Form, with the results documented accordingly. These are done by the Dietary Manager or qualified designee. The facility created a new QA team, The 2018 Annual Survey Plan of Correction QA Team, to implement the plan of correction. The facility identified residents with a BIMs score of 13 or higher and initiated 100% interviews of this population to ensure their current likes and dislikes were honored and documented on the Food Preference Form. These resident “like/dislike” food choice interviews are conducted at the direction of the Dietary Manager and designees approved by the QA team. No additional staff education outside of the frequency change of the interviews was needed at the time of the submission of this plan of correction. Moving forward, the frequency of the resident interview for food preferences is now upon admission, prn and at least every 6 months. The procedure was updated by the Chief Operating Officer of the facility and is in place at the time of this submission.	

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F 561	Continued From page 5 Interview on 5/15/18 at 2:39 PM with Resident #70 revealed she did not like meat, especially chopped meat. She further explained the chopped chicken did not taste "right." Other dislikes included pork meat and Cheerios. During the interview, the resident gave "likes" as brown bread and over easy eggs. Further interview revealed she did not get fresh fruit, except for bananas and she was "tired" of grits. Interview with the CDM, on 5/17/18 at 1:16 PM revealed she had not talked with the resident about her food preferences. The food preference list was initially completed on admission and she had not talked with the resident about the food, her likes and/or dislikes.	F 561	Following this new/updated procedure will ensure compliance with F 561. The 2018 Annual Survey Plan of Correction QA Team will next meet on 6/14/18. The 2018 Annual Survey Plan of Correction QA Team will both monitor and ensure plan of correction effectiveness and compliance. Logistically, the QA team will meet weekly to review a log of residents who are due for a 6 month interview/review. The review of the log for completion (including if food preference changes were made and documented) will occur during this QA meeting to ensure compliance. The 2018 Annual Survey Plan of Correction QA team will meet weekly for a minimum of the next 6 months and will meet monthly thereafter to ensure the plan of correction remains in compliance with regulations. The log tracking and analysis results will also be reported by the Dietary Manager at the Executive Quarterly QA meeting. The next scheduled Executive Quarterly QA meeting is scheduled for 7/6/18. The Dietary Manager and Nursing Home Administrator will be responsible for implementing this portion of the plan of correction. The facility alleges compliance will all aspects of this portion of the plan of correction by 6/14/18.	
F 607 SS=B	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3)	F 607		6/14/18

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F 607	Continued From page 6 §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to follow the abuse policy with the requirement to report abuse allegations within 2 hours of notification of the allegation. This was for 2 of 8 alleged abuse investigations completed by the facility. The findings included: The facility abuse policy "Allegations of Abuse, Neglect, Exploitation or Mistreatment with a revised date of 4/18/18 included in part: "1. All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Administrator of this facility and to other officials (including the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care	F 607	The opportunity to correct the past late reporting issue is not possible due to reporting guidelines. Moving forward, the facility has measures in place to report future allegations of abuse within 2 hours. To be clear, the facility reported all allegations of abuse, but two of the past allegations were outside of the 2 hour window. Upon a review with the NHA and the DON, it became obvious that a misunderstanding of the interpretation of the new regulations in this area had occurred. To prevent future deficient practice in this area, the COO in-serviced both of these employees along with current Unit Coordinators on 5/21/18 regarding on the most current CFR guidelines regarding abuse policies and reporting. These guidelines are also current in the facility policy and procedure manual for this area. . The COO educated the NHA and DON regarding expectations based on facility's policy and procedures from the CFR. The group voiced understanding that any	

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F 607	Continued From page 7 facilities) in accordance with State law through established procedures ..." Review of the abuse investigations since the last annual recertification revealed two investigations that were not reported according to the facility abuse policy. a. An investigation of staff to resident abuse that was reported by an aide to the administrator on 12/4/17 at 2:00 PM. The aide alleged a staff had grabbed a resident's hand due to being slapped by the resident. The resident allegedly slapped the staff on her bottom. Review of the report revealed the allegation was faxed to the state agency on 12/5/17 at 12:58 PM. b. An investigation of a visitor to resident allegation of abuse was reported on 3/14/18 (with no time recorded). Review of the report revealed the allegation was faxed to the state agency on 3/15/18 at 5:57 PM. Interview with the Administrator on 5/18/18 at 1:38 PM revealed he misunderstood the regulation. He explained it was his understanding, the report had to be sent within 2 hours if there was bodily injury.	F 607	allegation of abuse (with or without injury) would be reported within 2 hours of their awareness. The 2018 Annual Survey Plan of Correction QA Team will monitor and record allegations during their weekly meetings. Any allegation of abuse investigation file (including confirmation of submission time) will be reviewed during the weekly team meeting. If a reporting issue were to occur, it is to be communicated to the COO for compliance purposes. The 2018 Annual Survey Plan of Correction QA team will meet weekly for a minimum of the next 6 months and will meet monthly thereafter to ensure the plan of correction remains in compliance with regulations. An update of any allegations investigated /reported (including timely submission) will be made by the Nursing Home Administrator at the Executive Quarterly QA meeting. The next scheduled Executive Quarterly QA meeting is scheduled for 7/6/18. The Chief Operating Officer for the facility will be responsible for implementing this portion of the plan of correction. The facility alleges compliance will all aspects of this portion of the plan of correction as of 6/14/18.	
F 609 SS=B	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility	F 609		6/14/18

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F 609	Continued From page 8 must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to report abuse allegations within 2 hours of notification of the allegation. This was for 2 of 8 alleged abuse investigations completed by the facility. The findings included: The facility abuse policy "Allegations of Abuse, Neglect, Exploitation or Mistreatment with a revised date of 4/18/18 included in part: "1. All	F 609	The opportunity to correct the past late reporting issue is not possible due to reporting guidelines. Moving forward, the facility has measures in place to report future allegations of abuse within 2 hours. To be clear, the facility reported all allegations of abuse, but two of the past allegations were outside of the 2 hour window. Upon a review with the NHA and the DON, it became obvious that a misunderstanding of the interpretation of	

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F 609	Continued From page 9 alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Administrator of this facility and to other officials (including the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures ..." Review of the abuse investigations since the last annual recertification revealed two investigations that were not reported according to the facility abuse policy. a. An investigation of staff to resident abuse that was reported by an aide to the administrator on 12/4/17 at 2:00 PM. The aide alleged a staff had grabbed a resident's hand due to being slapped by the resident. The resident allegedly slapped the staff on her bottom. Review of the report revealed the allegation was faxed to the state agency on 12/5/17 at 12:58 PM. b. An investigation of a visitor to resident allegation of abuse was reported on 3/14/18 (with no time recorded). Review of the report revealed the allegation was faxed to the state agency on 3/15/18 at 5:57 PM. Interview with the Administrator on 5/18/18 at 1:38 PM revealed he misunderstood the regulation. He explained it was his	F 609	the new regulations in this area had occurred. To prevent future deficient practice in this area, the COO in-serviced both of these employees along with current Unit Coordinators on 5/21/18 regarding on the most current CFR guidelines regarding abuse policies and reporting. These guidelines are also current in the facility policy and procedure manual for this area. The COO educated the NHA and DON regarding expectations based on facility's policy and procedures from the CFR. The group voiced understanding that any allegation of abuse (with or without injury) would be reported within 2 hours of their awareness. The 2018 Annual Survey Plan of Correction QA Team will monitor and record allegations during their weekly meetings. Any allegation of abuse investigation file (including confirmation of submission time) will be reviewed during the weekly team meeting. If a reporting issue were to occur, it is to be communicated to the COO for compliance purposes. The 2018 Annual Survey Plan of Correction QA team will meet weekly for a minimum of the next 6 months and will meet monthly thereafter to ensure the plan of correction remains in compliance with regulations. An update of any allegations investigated /reported (including timely submission) will be made by the Nursing Home Administrator at the Executive Quarterly QA meeting. The next scheduled Executive Quarterly QA	

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F 609	Continued From page 10 understanding, the report had to be sent within 2 hours if there was bodily injury.	F 609	meeting is scheduled for 7/6/18. The Chief Operating Officer for the facility will be responsible for implementing this portion of the plan of correction. The facility alleges compliance will all aspects of this portion of the plan of correction as of 6/14/18.	
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would	F 623		6/9/18

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F 623	Continued From page 11	F 623		

be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance

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F 623	Continued From page 12 and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to provide the resident and resident representative a written notification for the reason for transfer to the hospital and failed to provide a copy of the notice to the Ombudsman for 3 of 3 residents (Resident #103, Resident #90 and Resident #80) reviewed for hospitalization. Findings included:	F 623	An internal review to determine the root cause of the deficiency yielded a finding that administrative staff did not fully understand the new regulation for this area. Specifically, that a transfer notice would be required for residents (or RPs if applicable or the Ombudsman) who were being sent out for acute transfers. The administrative staff did not think a transfer notice was required since the resident's	

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F 623	Continued From page 13 1. Resident #103 was admitted to the facility on 2/7/18 with diagnoses that included, in part, benign prostatic hypertrophy and history of malignant neoplasm of the bladder. A review of the most recent comprehensive minimum data set (MDS) assessment dated 2/14/18 revealed Resident #103 was cognitively intact. A review of the medical record revealed Resident #103's representative was a family member. A review of the medical record revealed Resident #103 was transferred to the hospital on 3/22/18 after he complained of abdominal pain. The resident did not return to the facility. No written notice of transfer was documented to have been provided to the resident, resident representative or Ombudsman. On 5/18/18 at 10:29 AM an interview was completed with Unit Manager #1. She stated when Resident #103 was admitted he had a catheter. She said the facility removed the catheter and began a voiding trial. The night the resident went to the hospital he complained of abdominal pain and his family member requested he be transferred to the emergency room. On 5/18/18 at 11:45 AM an interview was completed with the Director of Nursing (DON) and Chief Operating Officer (COO). The DON said the facility had not issued any notices of transfer/discharge when a resident transferred to the hospital. She stated she thought the facility only needed to issue transfer/discharge notices when they initiated a 30 day discharge.	F 623	return was expected/anticipated and that the facility had not formally discharged the resident. To correct the deficiency cited, the facility modified an internal process to send a transfer notice (with required appeal information) with all future acute transfers to a hospital (if the resident is sent directly from the facility). The notice will be provided to residents (and to resident responsible party if resident is not their own responsible party). The COO has spoken with the local Ombudsman representative as recently as 6/8/18, who acknowledges that the facility will now provide a monthly update of all acute transfers to the hospital from the previous month. This “report” will be done one month at a time to capture all acute care transfers and will be sent to a secure fax line at the Ombudsman office. The next scheduled report to the Ombudsman is due by 6/13/18. These two interventions will correct the previously deficient practice. The facility created a new QA team, The 2018 Annual Survey Plan of Correction QA Team, to implement the plan of correction. Specifically, the QA team directed in-servicing to medical records staff on the newly modified internal facility process to have the transfer notice as part of the standard discharge packet of information that goes with residents when transferred to the hospital/acute care setting. This notice was added and is now a standard part of the discharge/transfer paperwork. Additionally, a new procedure (Transfer to Acute Care Setting	

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F 623	Continued From page 14 On 5/18/18 at 11:48 AM an interview was completed with the Director of Social Services. She stated the facility had not sent copies of the transfer/discharge notices to the Ombudsman when a resident transferred to the hospital. On 5/18/18 at 1:00 PM an interview was completed with the Ombudsman. She said the facility had not sent her any notices of residents who transferred to the hospital. 2. Resident #90 was admitted to the facility on 11/25/16 with diagnoses which included: diabetes mellitus, atrial fibrillation, essential hypertension, anxiety, and a history of falls. The review of the Discharge Assessment dated 1/8/18 indicated Resident #90 had short-term memory problems with poor decision-making skills and was discharged to the hospital due to a fall with a major injury in his room at the facility. Review of the hospital records revealed Resident #90 was hospitalized on 1/8/18 for a laceration requiring staples to his forehead, as the result of the fall. The resident was re-admitted to the facility on 1/10/18. The review of the clinical record indicated Resident #90 or his Responsible Party did not receive a notice of transfer/discharge when he was discharged to the hospital. Also, there was no available documentation indicating the Ombudsman was notified when the resident was transferred to the hospital. During an interview on 5/18/18 at 11:45 a.m., the DON (Director of Nursing) and the COO (Chief Operating Officer) revealed the facility had not	F 623	Procedure) was created by the COO to ensure notification to responsible party (if applicable) by the clinical concierge who has access to that information. The facility now has a system to ensure 1) residents are given a transfer notice, 2) RPs receive a transfer notice (if applicable) and 3) The local Ombudsman receives a monthly report via fax as agreed mutually with the facility administration. The 2018 Annual Survey Plan of Correction QA Team will next meet on 6/14/18. The 2018 Annual Survey Plan of Correction QA team will meet weekly and will use the new Transfer to Acute Care Setting Procedure to guide their monitoring efforts. Specifically, a QA log/tool (List of Transfers to Acute Care Setting QA log) will be reviewed each week to review all discharges since the previous meeting. This will be done to ensure all residents have been given a transfer notice of rights, that responsible party(s) for resident have received transfer notice (unless resident is own RP) and that the resident's acute transfer is captured on the QA Log for monthly transmission to the Ombudsman. Completion of the three elements will be reflected in QA team documentation meeting notes for that week to demonstrate compliance. The Nursing Home Administrator for the facility will be responsible for implementing this portion of the plan of correction.	

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F 623	Continued From page 15 issued a notice of Transfer/Discharge to any resident when he/she was discharged to the hospital. Notices were only issued to residents when the facility initiated thirty day discharges to residents. During an interview on 5/18/18 at 11:48 a.m., the facility's Director of Social Services indicated the facility did not notify the Ombudsman when residents were transferred to the hospital. 3. Resident # 80 was admitted to the facility on 11/30/16 with diagnosis including a neuromuscular disorder, neurogenic bladder and history of a stroke. Review of the most recent Minimum Data Set (MDS) dated 2/28/18 indicated Resident #80 had no problems with short or long-term memory impairment and was cognitively intact. Review of the medical record revealed Resident #80 had symptoms of a stroke and was transferred to the hospital emergency room on 2/18/18. She was readmitted to the facility on 2/21/18. Review of the social worker ' s notes revealed no documentation regarding the reason for the transfer, notification of the Ombudsman or documentation a transfer notice was given to the resident or responsible party. Interview with the Social Worker (SW) on 5/16/18 at 2:42 PM revealed the admission coordinator informs the family about the bed hold policy. During the interview, the SW was not able to provide an answer regarding the transfer notice	F 623	The facility alleges compliance will all aspects of this portion of the plan of correction as of 6/15/18.	

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F 623	Continued From page 16 that is required on discharge. A follow up interview with the SW on 5/17/18 at 11:17 AM revealed the admissions coordinator would inform the Ombudsman of resident transfers/discharges. Interview with the admission coordinator on 5/17/18 at 11:18 AM revealed she did not have anything to do with discharges/transfers. She explained she only brings them into the facility. Interview with the administrator on 5/17/18 at 11:19 AM revealed the Director of Nursing (DON) had a form for transfers. A form was provided by the DON on 5/17/18 at 12:28 PM. The DON explained the form that was used, entitled "Resident/Patient Transfer Form" was sent with the resident to the hospital. Continued interview revealed the form included information for the hospital and was not given to the resident. The form did not contain the necessary information for resident rights, appeal procedures, or notification of the Ombudsman. Interview with the Chief Operating Officer on 5/18/18 at 4:00 PM revealed the transfer/discharge form with the necessary information was used for 30-day discharges. The form had not been utilized for all transfers/discharges.	F 623		
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.	F 641		6/9/18

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F 641	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interview, the facility failed to accurately code section O of the Significant Change Minimum Data Set (MDS) for 1 of 1 sampled resident reviewed for hospice care (Resident #17). Findings included: Resident #17 was admitted to the facility on 11/30/16 with diagnoses which included atherosclerotic heart disease. On 8/3/17 the Physician ordered a hospice consult for Resident #17. The resident was admitted to Hospice on 8/4/17 due to the diagnosis of atherosclerotic heart disease of native coronary artery without angina pectoris. A Significant Change Minimum Data Set (MDS) with the assessment reference date of 8/15/17 was completed to reflect Resident #17's change in health status. The MDS indicated the resident was severely, cognitively impaired. Hospice care was not coded on the MDS as the Special Program/Treatment received by the resident. Resident #17's Care Plan was updated on 8/7/17 to include hospice services with interventions. During an interview on 5/17/18 at 4:32 p.m., MDS Nurse #2 revealed the Significant Change MDS was completed as the result of Resident #17 began Hospice on 8/4/17. She stated due to human error, hospice care was not coded in Section O of the resident's Significant Change MDS.	F 641	To correct the deficiency cited, the facility corrected the previous MDS coding error omission (Hospice was not coded) for resident #17 and resubmitted that MDS assessment on 5/30/18. Using a root cause analysis, it was determined that the deficiency in question was a byproduct of human error by a MDS employee (the "code" was not manually entered). It was the only significant change assessment error noted during the survey. To ensure no other significant change assessment errors existed, the facility also audited all significant change assessments (n = 15) since the previous annual survey as that was the specific deficiency cited. No other errors were identified during that audit process by administrative nursing team members. The process for verifying the accuracy of the full MDS assessment (including significant change assessments) has been updated as of 6/7/18. The facility created a new QA team, The 2018 Annual Survey Plan of Correction QA Team, to implement the plan of correction. The updated process/procedure for verifying the accuracy of the full MDS assessment was in-serviced to the MDS (and other administrative staff members) by the COO on 6/7/18. A new QA tool (the Significant Change Accuracy Tracking QA Log) was designed and in-serviced to this same group as well. The internal process/procedure now calls for the full	

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F 641	Continued From page 18	F 641	MDS assessments (including significant change assessments) to be audited prior to submission/transmission; additionally, the MDS worker completing the assessment will no longer be allowed to audit/accuracy check their own work. The facility has 3 MDS staff members in total and none of the MDS staff members will be allowed to audit their own MDS assessment(s). The MDS staff members will only audit the specified MDS assessments of their co-worker(s). The internal QA audits for coding accuracy will increase the facility's ability to catch any MDS coding error prior to that point. The 2018 Annual Survey Plan of Correction QA Team will next meet on 6/14/18. The 2018 Annual Survey Plan of Correction QA team will meet weekly and will use the Significant Change Accuracy Tracking QA Log to guide their monitoring efforts. The 2018 Annual Survey Plan of Correction QA team will meet weekly for a minimum of the next 6 months and will meet monthly thereafter to ensure the plan of correction remains in compliance with regulations. During the QA meetings, the log of completed/audited MDS assessments will be reviewed by the team members to ensure auditing and accuracy efforts remain in place are effective as well. The MDS Coordinator will be responsible for bringing the log (including any supporting documentation) to the QA meetings. The MDS Coordinator will also be responsible for reporting the QA team's efforts at the Executive Quarterly QA meetings. The next scheduled	

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F 641	Continued From page 19	F 641	Executive Quarterly QA meeting is scheduled for 7/6/18. The MDS Coordinator for the facility will be responsible for implementing this portion of the plan of correction. The facility alleges compliance will all aspects of this portion of the plan of correction as of 6/15/18.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's	F 655		6/14/18

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F 655	Continued From page 20 admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete an individualized baseline care plan and failed to give a copy of the baseline care plan to the resident or responsible party for 3 of 4 new admissions reviewed. (Resident #81, Resident #71 and Resident #103) Findings included: 1. Resident #81 was admitted to the facility on 1/26/18 with diagnoses, in part, of pain in hip and leg, history of falling, Alzheimer's and anxiety. A record review on 5/17/18 at 2:00 PM revealed no documented evidence that a copy of the baseline care plan was given to the resident or the responsible party. The facility was unable to provide evidence that a baseline care plan had been completed for this	F 655	To correct the deficiency cited, the facility implemented a new policy and procedure for the creation and provision of baseline care plans. This was done as a result of an internal root cause analysis that identified a recent change from one EMR platform to another as a significant cause of the deficiency. This plus a misinterpretation of the regulatory guidelines for F655 are the causes for this previously deficient practice. Residents cited under F655 during the annual survey process are confirmed to now have a baseline or comprehensive care plan in place as of 6/7/18 and have been offered a copy of their most recent care plan if they did not already have that information. Moving forward, with the implementation of the new policy and procedure, F655 education/in-servicing and QA	

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F 655	Continued From page 21 resident. An interview conducted on 5/17/18 at 2:15 PM with the Minimum Data Set (MDS) assessment nurse revealed the computer system the facility used had capability to email care plans to responsible parties, but they were not using it as she felt most residents family members didn't have computer access. She stated they were not completing the baseline care plan. An interview conducted on 5/18/18 at 4:15 PM with the Administrator revealed his expectation was for the baseline care plans to be completed within 48 hours of admission and a copy given to the resident or the responsible party. 2. Resident #71 was admitted to the facility on 4/4/18 with diagnoses, in part, of hypertension and diabetes mellitus type 2. A record review of the care plan dated 4/4/18 indicated the care plan did not include a list of the resident's medications. A record review on 5/17/18 at 10:27 AM revealed no documented evidence that a copy of the baseline care plan was given to the resident or the responsible party. An interview conducted on 5/17/18 at 2:15 PM with the Minimum Data Set (MDS) assessment nurse revealed the computer system the facility used had capability to email care plans to responsible parties, but they were not using it as she felt most residents family members didn't have computer access. She stated they were not completing the baseline care plan.	F 655	tools/interventions; all residents will have baseline care plans completed within 48 hours and all families (if resident is not alert and oriented and their own responsible party) will have a care plan provided to them by the 21st day since admission. The facility created a new QA team, The 2018 Annual Survey Plan of Correction QA Team, to implement the plan of correction for this area of the plan of correction. At the time of this submission 6/8/18, the facility now has the capability for the MDS nursing department to generate a 48 hour/baseline care plan inside of the EMR. The base line care plans will be created by the MDS department within the EMR platform for floor and general staff to use accordingly. The baseline care plans will continue to be updated as more information is gathered as part of the existing comprehensive assessment and care planning process. Education was provided on by the COO for team members who actively participate either in the care plan creation or provision areas. Additionally, the facility created and is utilizing a QA log (the Baseline Care Plan Creation and Provision Log) to ensure it can both track the timely completion of the base line care plan and prove that base line care plans have been offered/provided to residents and/or resident representative (if resident is not alert/oriented and their own responsible party). The clinical concierge will be assisting the team in ensuring these are	

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F 655	Continued From page 22 An interview conducted on 5/18/18 at 4:15 PM with the Administrator revealed his expectation was for baseline care plans to be completed within 48 hours of admission and a copy given to the resident or the responsible party. 3. Resident #103 was admitted to the facility on 2/7/18 with diagnoses that included, in part, benign prostatic hypertrophy, pain and history of malignant neoplasm of the bladder. A review of the comprehensive Minimum Data Set (MDS) assessment dated 2/14/18 revealed Resident #103 was cognitively intact. A review of the medical record revealed a baseline care plan was completed 2/7/18. A review of the medical record revealed no documented evidence that a copy of the baseline care plan was given to the resident or resident representative. On 5/18/18 at 12:13 PM an interview was completed with MDS Nurse #1. She stated she had reviewed the baseline care plan with the resident and resident representative by the 21st day but had not given them a copy of the care	F 655	sent or mailed out timely (between the 14th and by the 21st day of the resident stay). The 2018 Annual Survey Plan of Correction QA Team will next meet on 6/14/18. The 2018 Annual Survey Plan of Correction QA team will meet weekly and will use the Baseline Care Plan Creation and Provision QA Log to guide their monitoring efforts. The 2018 Annual Survey Plan of Correction QA team will meet weekly for a minimum of the next 6 months and will meet monthly thereafter to ensure the F655 plan of correction remains in compliance with regulations. During the QA meetings, the QA log will be verified by team members for those residents triggered (based on admission date) for base line care plans. This ongoing review of the QA log will help the facility ensure its plan of correction remains in place and that interventions are effective as well, it will also help in verifying and proving that that residents have been provided base line care plans. The MDS Coordinator will be responsible for bringing the log (including any supporting documentation) to the QA meetings. The MDS Coordinator will also be responsible for reporting the QA team's efforts at the Executive Quarterly QA meetings. The next scheduled Executive Quarterly QA meeting is scheduled for 7/6/18. The MDS Coordinator and the Nursing Home Administrator for the facility will be responsible for implementing this portion	

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F 655	Continued From page 23 plan. She said the facility had switched to a new electronic medical record system and staff had discussed how the baseline care plan would be provided to residents and/or resident representatives but the facility had not started giving copies of the care plan. On 5/18/18 at 4:15 PM an interview was completed with the Administrator. He stated he expected a copy of the baseline care plan be given to the resident and/or resident representative by the 21st day.	F 655	of the plan of correction. The facility alleges compliance will all aspects of this portion of the plan of correction as of 6/14/18.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656		6/14/18

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F 656	Continued From page 24 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to implement the care plan for fall preventions for 1 of 6 sampled residents with falls. (Resident #29) The findings included: 1. Resident # 29 was admitted to the facility on 1/24/11 with diagnosis that included of progressive dementia. The quarterly Minimum Data Set (MDS) dated 3/5/18 indicated Resident #29 had long and short-term memory impairment and severe impairment with cognition. The MDS indicated she required extensive assistance with bed mobility and transfers. Resident #29 was assessed as having no falls during the past three months since the December quarterly MDS.	F 656	To correct the deficiency cited, the facility ensured the fall mats in question for resident #29 were in place as expected. A root cause analysis yielded that staff members did not return the mats to their correct position after resident care. Education has been provided for the nursing staff (nurses, medication aides and nursing assistants) and increased administrative monitoring using revised QA tools have also been implemented to correct this previously deficient practice. The facility created a new QA team, The 2018 Annual Survey Plan of Correction QA Team, to implement the plan of correction for this area of the plan of correction. Implementation includes in-servicing on 6/3/18 for all nursing staff members (nurses, medication aides and	

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F 656	Continued From page 25 Review of the updated care plan dated 3/19/18, included a problem of risks for falls related to a history of falls, abnormal posture, bilateral knee contractures and unable to stand or ambulate. The approaches included use of mats on the floor when the resident was in the bed. Observations on 5/14/18 at 3:12 PM revealed the fall mats were folded, against the side of the wall behind the privacy curtain. The resident was in the bed. Observations on 5/15/18 at 8:23 AM revealed Resident #29 was in the bed and the fall mats were folded, leaning against the wall beside the resident ' s bed. Observations on 5/16/18 at 1:20 PM the floor mats remained against the wall and the resident was in the bed. Observations on 5/17/18 at 8:31 AM revealed one fall mat was on the floor, on resident's left side of the bed. The other floor mat was folded and against the wall beside the resident's bed. The resident was in the bed, sleeping. Interview with the Nursing Aide (NA) #2 and Nurse #3 revealed the mats were just implemented. NA#2 explained the mat should be on one side of the bed. The Nurse #3 and NA#2 explained the resident had not had any falls and they thought the mats may have been discontinued. The NA thought the purpose of the fall mat was because the resident would put her leg over the side of the bed. Interview with MDS Nurse #1 on 5/17/18 at 5:02 PM revealed the fall mats were to be on both	F 656	nursing assistants) on facility expectations for placement of fall mats before and after resident care. New nursing staff employees will also receive this information as part of their general facility orientation. The previously utilized Fall Prevention Intervention Log has been modified by the Director of Nursing and is now referred to as the Prevention Intervention QA Log. This QA log will be updated/kept current by the Director of Nursing (or Administrative nurse designee) and will be audited at least 3x per week to determine compliance at the point of care. Results are monitored by the DON. The facility also modified the Departmental Rounding QA tool to include fall mat placement as this will also increase the monitoring throughout the building on a daily basis. Any issues with fall mats are corrected, including re-education or corrective actions with staff, as/if they are discovered. The 2018 Annual Survey Plan of Correction QA Team will next meet on 6/14/18. The 2018 Annual Survey Plan of Correction QA team will meet weekly and will use the QA tools (Prevention Intervention QA Log and the Departmental Rounding QA Tool) to guide their monitoring efforts. The 2018 Annual Survey Plan of Correction QA team will meet weekly for a minimum of the next 6 months and will meet monthly thereafter to ensure the F655 plan of correction remains in compliance with regulations. This ongoing review of the QA logs will help the facility ensure its plan of correction	

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F 656	Continued From page 26 sides of the bed for fall prevention. Interview with the Director of Nursing on 5/18/18 at 4:00 PM revealed she would expect the care plan interventions to be used by the staff. The floor mats should have been on the floor next to the resident ' s bed on both sides.	F 656	remains in place and that interventions are effective as well. If additional interventions or QA tools are needed, the facility will identify the need and utilize a QAPI format to document their efforts. The Director of Nursing will be responsible for bringing the log (including any supporting documentation) to the QA meetings. The Director of Nursing will also be responsible for reporting the QA team's efforts at the Executive Quarterly QA meetings. The next scheduled Executive Quarterly QA meeting is scheduled for 7/6/18. The Director of Nursing for the facility will be responsible for implementing this portion of the plan of correction. The facility alleges compliance will all aspects of this portion of the plan of correction as of 6/14/18.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on resident, staff, physician and nurse practitioner interviews and record review the	F 684	To correct the deficiency, the facility spoke directly with resident #80 on	6/14/18

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F 684	Continued From page 27 facility failed to obtain physician orders and failed to administer a medication according to physician orders for one of one sampled residents (Resident #80) receiving a weekly intramuscular injection. The findings included: Resident #80 was admitted to the facility on 11/30/16 with diagnosis including a neuromuscular disorder, neurogenic bladder and history of a stroke. Review of the most recent Minimum Data Set (MDS) dated 2/28/18 indicated Resident #80 had no problems with short or long-term memory impairment, was cognitively intact and required extensive to total assistance with activities of daily living. Review of the Medication Administration Records (MAR) from August 2017 to October 2017, revealed Avonex injections (used to treat the neuromuscular disorder to decrease the number of flare-ups and slow the occurrence of some of the physical disability common to the disease) were provided every week as ordered. There were no documented refusals by the resident. Review of the MAR for November 2017 to January 2018 revealed there were some documented refusals of the medication Avonex and some documentation the medication was provided. There was no documentation as to why the resident refused the medication. Resident #80 was admitted to the hospital on 2/18/18 and returned 2/22/18 for possible stroke.	F 684	5/18/18 to determine the root cause of why the medication (Avonex) was being refused. During that conversation the resident provided a list of reasons for refusing and a set of stipulations under which medication would not be refused. Following an interdisciplinary discussion, it was decided by the facility NP that the resident should be seen by a neurologist. The opportunity to see a local neurologist (previous neurologist was in another state) was accepted by the resident and an appointment was made for 6/27/18 which was the earliest available as a new patient. Facility Medical Director is aware and in agreement with NP/resident decision. Resident #80 continues to refuse the medication and these refusals are documented by staff. The pharmacy provider sent a 4 pack of the medication which will be stored appropriately until resident is seen by the local neurologist. Medication confirmed to be in the facility on 6/8/18 and is available were resident to not refuse OR when new neurologist provides orders for administration following the 6/27/18 appointment. The facility created a new QA team, The 2018 Annual Survey Plan of Correction QA Team, to implement the plan of correction. Actions deemed necessary for this corrective plan included an in-service directed by the D.O.N. with all nurses and medication aides regarding refusals. The in-service was initiated on 6/3/18 and will continue until all nurses and medication aides have been in-serviced. If any nurse or medication aide has not been	

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Re-Admission physician orders, dated 2/22/18 included the administration of Avonex 30 micrograms IM (intramuscular) Pen Injector every week on Monday.

Review of the MAR for February to May 2018 revealed the resident refused the medication. There was no documentation to explain why the resident refused the medication.

Interview on 5/15/18 at 1:31 PM with Resident #80 revealed she had not had the injection that day. She further explained she would take the injection, but nurses would inform her the medication was not available. Resident #80 stated she did not let some of the nurses give the injection due to their lack of knowledge on how to administer the injection. Further interview revealed she had informed the nurse she would take the injection if the Unit Manager #1 would give the injection.

Interview with Nurse #2 on 5/16/18 at 10:48 AM revealed the medication was not in the refrigerator for the dose on Monday. She further explained it had not come in from pharmacy. Further interview revealed when she had worked with the resident, she would refuse the injection. The medication was to be given weekly on Monday. During the interview, Nurse #2 explained the staffing for the resident's hall varied, and was not the same nurse on Mondays.

Interview with Unit Manager #1 on 5/16/18 at 2:00 PM revealed the resident usually refused the medication. She was not asked to give the medication on Monday, 5/14/18.

Interview with the Nurse Practitioner (NP) on

in-serviced by the desired date of compliance, that employee will be in-serviced upon return for their next scheduled shift. Also, the facility will continue the in-service, providing the information during the general and nursing specific portion of the new employee orientation process. This in-service also specifies what to do were any resident to refuse the same medication or treatment 3x in a row. The 2018 Annual Survey Plan of Correction QA Team will next meet on 6/14/18.

The 2018 Annual Survey Plan of Correction QA Team has utilized technology within their new EMR system (LG) to create an alert report anytime a medication is refused. The QA Team members, including designees such as the Unit Coordinators and the Weekend Supervisor, will print these alerts daily to be able to track any resident who may refuse a medication or treatment 3x in a row. The facility medical director was in agreement with this decision and will be updated after the facility investigates and determines if additional changes may be needed for the medication being refused (examples = changing medication/intervention, discontinuing a medication, altering dose, etc based on the specific information available during the investigative process). To track the QA monitoring efforts, the facility created a new QA Tool, The Medication and Treatment Intervention Refusal Tracking Log, to record these occurrences for any resident who refuses 3 or more times in a

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F 684	Continued From page 29 5/16/18 at 2:45 PM revealed she was aware the resident was refusing the medication in February. It was her understanding, the staff would only order the medication if she would accept the injection. She was not aware it was not available, or that the resident would allow the injection if the unit manager would administer the injection. The NP was asked what her course of action would include now that she was aware of the resident ' s refusals. She explained a referral back to the neurologist for assessment for the need of the medication and how to proceed with dosing/administration. The NP further explained, if the nurse manager was not available or at the facility, it would be a problem for the injection to be given. Interview with pharmacist at the facility pharmacy on 5/16/18 at 3:08 PM revealed the medication had not been filled from February 2018 to present. He explained the pharmacy would wait for approval from the facility for any medication greater than 300.00 dollars. The pharmacy had not heard back from the facility to fill the order dated for February 2018. Interview with the DON on 5/17/18 at 11:25 AM revealed she and the NP reviewed the orders for the medications that were over 300.00 dollars. The NP then reviews to see if a different medication could be given. A form that the DON used was provided to make the decision to order the medication. This form was dated 2/22/18 and entitled "High Cost Medication Approval Request" with Resident #80 ' s name, the medication Avonex Pen and the cost of $7415.63 for a kit of 4 injections. The form indicated the medication had not been approved ("No" was checked) and was signed by the DON. This form indicated "if	F 684	row, including the outcome of the investigation. The daily printouts from the LG alerts will be kept in the same notebook that includes the QA tracking log of activity. The 2018 Annual Survey Plan of Correction QA team will meet weekly for a minimum of the next 6 months and will meet monthly thereafter to ensure the plan of correction remains in compliance with regulations. The printout audits, log tracking and analysis results will also be reported by the D.O.N. at the Executive Quarterly QA meeting. The next scheduled Executive Quarterly QA meeting is scheduled for 7/6/18. The Director of Nursing will be responsible for implementing this portion of the plan of correction. The facility alleges compliance will all aspects of this portion of the plan of correction by 6/14/18.	

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no, please indicate: - if the order is to be D/C ' d (discontinued) Yes/No and - Alternate order ..." This was left blank. A note was written at the bottom of the form, with no date, or signature "Not to be ordered until resident is agreeable to treatment, per conversation with provider."

Follow up interview on 5/17/18 at 4:00 PM with the DON revealed she had not spoken with the resident to understand why she was refusing the medication. The former provider had agreed to not order the medication until the resident agreed to take the injection.

Follow up interview on 5/18/18 at 10:00 AM with the NP revealed she had not reviewed the form, as she started with the facility on March 12th.

Interview on 5/18/18 at 11:00 AM with the Chief Operating Officer (COO) revealed the order should have either been discontinued or attempt to give the medication. He agreed the medication would need to be ordered if it was to be offered.

Interview on 5/18/18 at 1:00 PM revealed the COO had spoken with Resident #80 on 5/18/18. She had given him the reasons she had refused the injection and agreed to take the medication if Unit Manager #1 would administer the injection.

Interview with the primary physician was conducted on 5/18/18 at 4:15 PM. Interview revealed he was informed a couple of weeks ago she was refusing the medication. He further explained he had not visited the resident to discuss her refusals. The physician explained in Resident #80 ' s case, the lack of the medication had not caused her disease to become worse, and she had not experienced any decline.

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F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to apply bunny boots for a resident at risk for pressure ulcers for 1 of 2 residents (Resident #63) reviewed for pressure ulcers. Findings included: Resident #63 was admitted to the facility on 4/19/16 with diagnoses, in part, of dementia with behavioral disturbance, dysphagia and chronic kidney disease. A record review revealed a nurses note dated 3/9/18 that indicated redness to left heel. Bunny boots were applied, nurse practitioner and responsible party were notified and a note was left for the wound nurse. A review of a Minimum Data Set (MDS) assessment dated 3/28/18 indicated the resident	F 686	To correct the deficiency, the facility administrative team spoke with staff and with resident #63 to determine why bunny boots were not always in place. The information obtained allowed the facility to determine that staff oversight (not applying, not documenting self-removal) contributed to the deficiency of the bunny boot omission. Note: resident #63 has a history of refusing the intervention (bunny boots) as evidenced by 3 refusals documented in the month of May 2018 and 2 refusals as of June 7, 2018. Resident's skin integrity remains intact and staff are applying the bunny boots unless resident refuses, which as referenced is now being documented as well. The facility audited to determine if other residents who receive bunny boots (n = 5 residents) were having similar issues and none were identified among	6/9/18

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F 686	Continued From page 32 required two person extensive assistance with bed mobility and transfers, was always incontinent, was at risk for developing pressure ulcers and had no current pressure ulcers. Resident #63 had moderately impaired cognition. A review of the care plans updated on 4/11/18 revealed a problem of moderate risk for skin breakdown with a goal to have no pressure ulcer daily for 90 days and an intervention for bunny boots to bilateral heels. A review of the physician orders for March 2018 revealed an order for bunny boots to bilateral heels, maintain while in bed and check for placement dated 3/9/18. An observation on 5/16/18 at 9:00 AM revealed the resident lying in bed without bunny boots. An observation on 5/17/18 at 3:30 PM revealed the resident lying in bed without bunny boots. An observation on 5/18/18 at 8:20 AM revealed the resident lying in bed without bunny boots. An interview conducted on 5/18/18 at 1:36 PM with Nurse Aide (NA) #1 revealed she didn't know why the resident didn't have bunny boots on. An interview conducted on 5/18/18 at 1:40 PM with Nurse #1 revealed she didn't know why Resident #63 didn't have bunny boots on. She stated maybe the staff wasn't putting them on anymore because sometimes she kicks them off. An interview conducted on 5/18/18 at 2:21 PM with the Director of Nursing (DON) revealed her expectation was for staff to follow physician	F 686	the group of 4 other residents utilizing bunny boots as of 6/8/18. The facility created a new QA team, The 2018 Annual Survey Plan of Correction QA Team, to implement the plan of correction. Actions deemed necessary for this corrective plan included an in-service (Implementing Prevention Interventions) which was directed by the D.O.N. and initiated on 6/3/18 for all nursing staff (nurses, medication aides and nursing assistants). In-service was initiated on 6/3/18 and will continue until all nursing staff have been in-serviced. If any nursing staff member who should receive this in-service has not been in-serviced by the desired date of compliance, that employee will be in-serviced upon return for their next scheduled shift. Also, the facility will continue the in-service, providing the information during the general and nursing specific portion of the new employee orientation process. The 2018 Annual Survey Plan of Correction QA Team will next meet on 6/14/18. To monitor for plan of correction effectiveness and compliance, the 2018 Annual Survey Plan of Correction QA team modified a previously existing internal QA document (now titled the Prevention Intervention Monitoring QA Log) to include bunny boots. The additional monitoring for compliance in this area will be completed a minimum of 3x each week by an administrative employee/designee of the 2018 Annual Survey Plan of Correction QA team.	

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F 686	Continued From page 33 orders.	F 686	Increased intervention monitoring at the point of care, coupled with the re-education for the nursing staff should promote and ensure compliance. The monitoring efforts will be turned in and reviewed during the 2018 Annual Survey Plan of Correction QA team meetings. The QA team will meet weekly for a minimum of the next 6 months and will meet monthly thereafter to ensure the plan of correction remains in compliance with regulations. Any additional changes or improvements necessary to ensure continued compliance will be reflected in the notes of the weekly QA team meetings. The audits and analysis results will also be reported by the D.O.N. at the Executive Quarterly QA meeting. The next scheduled Executive Quarterly QA meeting is scheduled for 7/6/18. The Director of Nursing will be responsible for implementing this portion of the plan of correction. The facility alleges compliance will all aspects of this portion of the plan of correction by 6/14/18.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690		6/14/18

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F 690	Continued From page 34 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review the facility failed to provide an irrigation of an indwelling urinary catheter for one of one sampled residents with a catheter (Resident #80). The findings included: Resident #80 was admitted to the facility on 11/30/16 with diagnosis including a neuromuscular disorder, neurogenic bladder and	F 690	To correct the deficiency, the facility leadership reviewed the survey findings in the 2567 report in addition to speaking with the nurse in question regarding the deficient practice. The nurse in question was in-serviced on 6/7/18 and was required to provide a return demonstration of proper indwelling catheter irrigation technique. The in-service, test of knowledge on proper indwelling catheter	

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F 690	Continued From page 35 history of a stroke. Review of the most recent Minimum Data Set (MDS) dated 2/28/18 indicated Resident #80 had no problems with short or long-term memory impairment, required extensive to total assistance with activities of daily living. This MDS included the use of an indwelling urinary catheter. The care plan dated 3/21/18 included a problem of a suprapubic catheter due to neurogenic bladder. The approaches included catheter care for the resident every shift and as needed, ongoing assessment of color, clarity and character of resident's urine, and change resident's catheter tubing/ bag per protocol. A telephone order dated 1/25/18 to irrigate the supra pubic catheter with 50 ml (milliliters) of Renacidin solution into the bladder. (Renacidin is a sterile solution that reduces the formation of crusts and stones in the bladder when an indwelling catheter is used.) Instructions provided for the nurse to let the solution set 15 minutes in the bladder and then drain. The irrigation was to be provided every other day. Interview with Resident #80 on 5/15/18 at 9:23 AM revealed she had not had her catheter irrigated since Saturday (three days ago). She further explained the nurses did not irrigate the catheter on a regular scheduled basis. Interview with Nurse #2 on 5/16/18 at 1:43 PM revealed she was not aware the irrigation was to be done. She explained a medication aide was on Resident #80 ' s hall, and she had not seen the Medication Administration Record (MAR). The treatment was not on the Treatment	F 690	care and return demonstration along with MD order clarification on 6/7/18 are believed to have corrected the previously deficient practice. The facility only has 1 indwelling catheter (the resident in question) as of the time of submission of this plan of correction and no other residents were affected. The facility created a new QA team, The 2018 Annual Survey Plan of Correction QA Team, to implement the plan of correction. Actions deemed necessary for this corrective plan included an in-service (Catheter Care) which was directed by the D.O.N. and initiated on 6/3/18 for all nurses. The in-service will continue until all nurses have been in-serviced and tested on catheter care. If any nurse who should receive this in-service and test has not been in-serviced by the desired date of compliance, that employee will be in-serviced upon return for their next scheduled shift. Also, the facility will continue the Catheter Care in-service, providing the information/test during the general and nursing specific portion of the new employee orientation process. Note: a live return demonstration was not realistic for all nurses on staff as the facility only has 1 resident with an indwelling catheter and procedure would not have been appropriate or timely to do more than once per day. Therefore, the return of knowledge was verified with a test of the in-serviced information. Also, to ensure nurse staff knowledge remains appropriate specific to catheter care, the facility has added catheter care to the	

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F 690	Continued From page 36 Administration Record. Review of the MAR revealed it had been checked as completed with a "0". Interview on 5/16/18 at 1:50 PM with the Medication Aide #1 revealed she had checked off the irrigation was done. She explained she would usually check it off, and the nurse knew to do the irrigation because she could not perform that task. Review of the May MAR revealed it was documented as provided and had not been refused by the resident. Observations on 5/16/18 at 2:55 PM revealed Nurse #2 donned her gloves, disconnected the tubing from the catheter connector, obtained the pre-filled irrigation syringe from her uniform pocket, inserted the tip of the prefilled irrigation syringe into the tubing and flushed the catheter. The tubing was then reconnected to the catheter and the flush began draining out of the tubing. Interview immediately afterwards with Nurse #2 revealed she was not aware the irrigation order instructions included to have the solution remain in the bladder for 15 minutes. The nurse left and did not return to make any changes to the catheter tubing or the catheter. Interview with the DON on 5/18/18 at 4:00 PM revealed she would expect the nurse to provide the irrigation according to the physician order. The connection between the catheter and tubing should have been wiped with alcohol before and after irrigation.	F 690	annual skills check off list due again in November of 2018. This will be repeated annually unless otherwise noted in the QA minutes. The 2018 Annual Survey Plan of Correction QA Team will next meet on 6/14/18. To monitor for plan of correction effectiveness and compliance, the 2018 Annual Survey Plan of Correction QA team will monitor this plan of correction which centers on education. A roster of nurses will be maintained, along with their testing results verifying knowledge. The QA team will also be responsible for ensuring the annual skills check off is completed with the results being logged to verify completion. The QA team will continue weekly for the next 6 months and will make changes as necessary to ensure compliance is maintained. Any efforts necessary to improve this portion of the plan of correction will be directed by the team, with efforts documented as well. The Director of Nursing will be responsible for implementing this portion of the plan of correction. The facility alleges compliance will all aspects of this portion of the plan of correction by 6/14/18.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812		6/14/18

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F 812	Continued From page 37 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. §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 observations and staff interviews, the facility failed to ensure sanitary conditions in the kitchen by failing to reseal and date opened food items in 1 of 1 walk-in freezer; and stacking and storing cleaned dishware wet. Findings included: 1. During the tour of the kitchen on 5/14/18 at 9:57 a.m., 7-plates, 7-meal tray bottom covers, 2-sectional plates and 10-meal trays were observed stacked wet on top of the milk cooler. An interview with a dietary aide revealed these items were stacked on the milk cooler for transportation to one of the four facility's unit kitchens for use during the lunch meal service. During an observation of the kitchen on 5/17/18 at 11:35 a.m., 11-meal tray lid covers were	F 812	To correct the deficiency during the survey, the facility immediately removed the unlabeled bags of food in addition to correcting any lids that had moisture. Utilizing root cause analysis, the team determined via internal investigation that 1) there was a lack of understanding by dietary staff with the labeling of items that were returned to their original box/package and 2) a delay in clearing the tables after the meal on the day in question, led to a lack of drying time for the lids prior to usage. Both of these have been addressed via education to dietary staff and no issues have been found to deficient in these areas since the time of the annual survey (via monitoring by the NHA and Dietary Management staff).	

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F 812	Continued From page 38 stacked wet on a delivery cart in preparation for transportation to one of the four unit kitchens. The Dietary Manager removed and returned all of the meal tray lid covers to the dishwashing machine to be rewashed. 2. During the tour of the kitchen on 5/14/18 at 10:05 a.m., there were food items stored in the walk-in freezer that were opened and not dated and labeled: 1-bag of porkchops, 1-bag of chuckwagon patties, 1-bag of ribbettes, and 1-bag of mixed vegetables. The Dietary Manager removed the items from the freezer.	F 812	The facility created a new QA team, The 2018 Annual Survey Plan of Correction QA Team, to implement the plan of correction. Actions deemed necessary for this corrective plan included an in-service (Labeling of opened items/Lid washing and drying expectations) which was directed by the facility's Executive Chef and presented to Dietary staff members, The dietary specific in-service will continue until all dietary members have been in-serviced on opened food container labeling expectations and lid washing/drying expectations. Should any dietary staff member not sign off on this in-service prior to the compliance date, the dietary employee in question will be in-serviced upon return for their next scheduled shift. During administrative follow up and monitoring, it was determined the facility could further or better prevent deficient practice in this area by increasing the number of "extra" lid dome and base plate covers. An additional 12 cases (108 sets) were ordered on 6/8/18 and will allow the facility to have ample backups in the event unexpected delays in dishwashing/drying occur. This invoice, in-service and monitoring will be reviewed during the next 2018 Annual Survey Plan of Correction QA Team meeting (will next meet on 6/14/18). To monitor for plan of correction effectiveness and compliance, the 2018 Annual Survey Plan of Correction QA team will monitor this plan of correction which centers on and around education	

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F 812	Continued From page 39	F 812	and additional oversight/monitoring and creating a surplus of supplies. The QA Team created a QA monitoring tool which would allow the NHA (or designee), Dietary Manager or Executive chef to conduct unannounced audits of labeling in the food storage areas and the dish washing/drying area. This QA audit tool will be completed a minimum of 3x a week to ensure that education efforts were in fact sufficient to prevent future deficient practice. The 2018 Annual Survey Plan of Correction QA team will continue weekly for the next 6 months and will make changes as necessary to ensure 1) education is for 100% of dietary staff, 2) audits are completed 3x or a week (minimum) and 3) results are discussed and analyzed by the QA team in the event additional interventions are necessary to promote ongoing compliance. The Nursing Home Administrator will be responsible for implementing this portion of the plan of correction. The facility alleges compliance will all aspects of this portion of the plan of correction by 6/14/18.	
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the	F 865		6/14/18

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F 865	Continued From page 40 promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility's Quality Assessment and Assurance Committee (QA and A) failed to implement, monitor and revise as needed the action plan developed for the recertification survey dated 6/9/17, in order to achieve and sustain compliance. This was for two recited deficiencies on a recertification survey on 5/18/18. The deficiencies were in the areas of resident assessment. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referenced to: 1. a. F278: The recertification survey on 6/9/17 cited the facility for failure to code the Minimum Data Set accurately for 1 of 38 sampled residents regarding active diagnosis and limitation in range of motion.	F 865	This deficiency, which is due to a repeated issue in another area, was analyzed and determined that due to human error with a previous EMR system, an expanded number of audit areas of the MDS assessments are necessary. The facility submitted a plan of correction in 2017 which was accepted and which had been followed. QAPI efforts referenced at that time were successful as there were no new deficient practices in 2018 from previously cited specific areas of the MDS assessment from the 2017 survey. Using QAPI, the expansion of the MDS assessment areas audited for accuracy coupled with the new EMR system (LG) were determined to be necessary to prevent future tags in this area. Specific to the deficient practice cited during the 2018 annual survey, please refer to corrective actions/interventions with F 641. The facility has now modified the internal	

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F 865	Continued From page 41 The recertification survey on 5/18/18 cited the facility at F641 for failure to code the Minimum Data Set accurately for 1 of 1 sampled resident that received hospice services. b. F280: The recertification survey on 6/9/17 cited the facility for failure to update the care plan for 2 of 5 sampled residents for unnecessary medications and 1 of 1 sampled residents with dialysis. The recertification survey on 5/18/18 cited the facility at F 657 for failure to update the care plan for 1 of 1 sampled residents with dialysis. Interview with the Administrator on 5/18/18 at 1:57 PM revealed the QA and A met on a monthly basis and reviewed the citations from the previous year specific to the areas that were cited. The audits did not include all areas of the Minimum Data Set or care plans.	F 865	QA process/audit of the MDS assessment to allow for a complete review of full MDS assessments (including significant change assessments) by a second MDS nurse/RN with qualifications. This expanded MDS auditing process went into effect on 6/7/18 and will continue indefinitely, at a minimum through the next annual survey process. Each MDS nurse currently employed by the facility has been in-serviced by a corporate team member regarding the expectation, the facility DON and NHA were also in-serviced to ensure the expectation is clear and followed. Any new MDS staff member(s) will be in-serviced as well if/when they are added, this would occur during the orientation process. A QA verification sheet and log were created and implemented to track the review(s) for MDS accuracy and to prove the audits/reviews are completed. The 2018 Annual Survey Plan of Correction QA Team will next meet on 6/14/18. To monitor for plan of correction effectiveness and compliance, the 2018 Annual Survey Plan of Correction QA team will monitor this plan of correction. The QA Team created a QA monitoring tool (MDS Assessment Accuracy Verification Tool/Log) which would allow the MDS staff to verify the accuracy of the assessment prior to submission/transmission. The audits will be completed by the MDS staff (not of their own work) or a qualified RN designee and logged verifying the audit. The audits will be for all full (including	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SHANNON GRAY REHABILITATION & RECOVERY CENTER	2005 SHANNON GRAY COURT JAMESTOWN, NC 27282

(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 865	Continued From page 42	F 865	significant change) MDS assessments. The summary results of the MDS Assessment Accuracy Verification Tool/Logs will be presented to the 2018 Annual Survey Plan of Correction QA team at least monthly and will continue through the next survey process at a minimum. These results (with QAPI analysis format) will also be reported will also be reported by the MDS Coordinator at the Executive Quarterly QA meeting. The next scheduled Executive Quarterly QA meeting is scheduled for 7/6/18. The MDS Coordinator and the Nursing Home Administrator will be responsible for implementing this plan of correction. The facility alleges compliance will all aspects of this portion of the plan of correction by 6/14/18.	