STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345149	A. BUILDING _____ B. WING _____	C 05/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WINSTON SALEM	4911 BRIAN CENTER LANE WINSTON-SALEM, NC 27106

(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 000	INITIAL COMMENTS A recertification, complaint investigation and onsite revisit survey was conducted on 5/17/18. Tag F584 was corrected as of 5/17/18. Repeat and new tags were cited as a result of the complaint investigation survey that was conducted at the same time as the revisit. The facility is still out of compliance. On June 21, 2018, technical corrections were made to tag F600 and tag F 742. A date correction was made to tag 600. A date correction and severity change was made to tag F742.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550		6/6/18

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

Electronically Signed | 06/12/2018

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

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F 550	Continued From page 1 residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to provide timely transfer assistance from wheelchair to bed to maintain a resident's dignity for 1 of 3 residents (Resident #36), The findings included: 1. Resident #36 was admitted to the facility 4/10/18 with the diagnoses of anemia, hypertension, and diabetes. The Admission Minimum Data Set (MDS) dated 4/17/18 indicated Resident #36 had no cognitive impairment, no behaviors, and no rejection of care. Resident #36 required one to two person extensive assistance with bed mobility, transfers, toileting, and personal hygiene.	F 550	F550 Resident Rights/Exercise of Rights 1. Process that lead to the deficiency: The alleged noncompliance occurred when NA #1 did not provide timely assistance for resident #36 to transfer from their wheelchair to the bed on May 14th during the 3 to 11 shift. 2.Correction for specific deficiency cited: Resident # 36 was assisted to transfer from the wheelchair to bed at 740 pm on May 14th 2018. The Director of Nursing on 5-14-2018 assessed resident # 36 for any signs and symptoms of skin break down,or problems with range of motion, the Director of Nursing also ask the resident if she was in pain at that time, The resident stated she was ok and was not in	

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F 550	Continued From page 2 During an interview on with Resident #36 on 5/14/18 7:02 PM the resident was found in her room beside her bed in her wheel chair. She stated she had asked staff for assistance to transfer to her bed at approximately 5:00 PM, but had not received assistance yet. Resident #36 stated that the longer she sat in her wheelchair the stiffer her body would get and that she hated asking staff to help her because if she was stiff and not able to help, they would get frustrated with her. During an interview on 5/14/18 at 7:15 PM the resident's Nurse Assistant (NA #1) came into the room. When this surveyor asked the NA if she could help the resident back to bed, the NA stated that she had been waiting on her partner to help transfer Resident #36 to her bed, and then walked out of the room. During an observation on 5/14/18 at 7:40 PM two NAs were observed moving Resident #36 to her bed. During an interview with the Administrator on 5/17/18 at 6:20 PM, she stated that it was her expectation for staff to address residents' requests in a timely manner and to maintain the resident's dignity while performing daily tasks. When asked about the observation and the amount of time it took staff to transfer the resident to her bed, she stated that was too long to have to wait for assistance.	F 550	pain at this time. NA#1 was re-educated on timely assistance when a resident request to be transferred from their wheelchair to bed. 3.The monitoring processes and systemic changes to ensure plan of correction is effective: Starting on 6/6/18 to the Director of Nursing services interviewed current residents with a BIMS score of 8 and above to identify if they are assisted timely when assistance is requested to transfer from wheelchair to bed. This information is documented on an interview tool and no other residents were identified for not receiving timely assistance when requested to transfer from wheelchair to bed. Starting on 6/6/2017 the Director of Nursing services will complete re-education with current Certified Nursing Assistants and Licensed Nurses. This education will include timely assistance for residents who request to transfer from their wheelchair to the bed. Any Certified Nursing Assistant or Licensed Nurse not re-educated prior to /6/2018 will not be allowed to work until re-education has occurred. Effective 6-6-2018 newly hired Certified Nursing Assistants and Licensed Nurses will receive education on timely transfers for residents who request to transfer from the wheelchair to bed. The Director of Nursing services will monitor the compliance of assisting	

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F 550	Continued From page 3	F 550	residents who request assistance to transfer from their wheelchair to bed by completing an interview audit with 5 residents with BIM scores 8 or above daily times 14 days, then weekly times 4 weeks, then monthly times 3 months or until a pattern of compliance is maintained. Effective 6-6-2018 the Director of Nursing Services will report the findings of the audits to the Quality Assessment and Assurance Committee (QAA) for any additional monitoring or modification of this plan monthly for 5 months or until a pattern of sustainable compliance is maintained. The Quality Assessment and Assurance Committee (QAA) can modify this plan to ensure the facility remains in substantial compliance. 4. Effective 6-6-2018 the Administrator and Director of Nursing Services are responsible to ensure implementation of this plan of correction for this alleged noncompliance and to ensure the facility remains in substantial compliance.	
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 600		6/5/18

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F 600	Continued From page 4 §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and resident interview the facility failed to prevent neglect by not providing mental health services for 1 of 1 residents (Resident #189) who voiced feelings of depression and exhibited signs and symptoms of anxiety. Findings included: Resident #189 was admitted to the facility initially on 4-25-18 and then readmitted 5-10-18 after a 5-day hospital stay. Resident #189 was admitted to the facility with multiple diagnoses which included neuromuscular dysfunction, tremors, anxiety, and chronic obstructive pulmonary disease. The Minimum Data Set (MDS) dated 5-2-18 revealed that resident #189 was moderately cognitively intact and had feelings of depression 12-14 days, feeling tired 7-11 days and a poor appetite 7-11 day. During an interview with Resident #189 on 5-15-18 at 10:21am she expressed feeling "helpless" because she was no longer as independent. The resident was tearful and stated she cried every day. She denied speaking to anyone about her feelings since she was admitted to the facility.	F 600	F 600 Freedom from Abuse and Neglect 1.Process that lead to the deficiency: The alleged noncompliance occurred when Resident #189 did not receive mental health services after voicing feelings of depression and exhibiting signs of symptoms of anxiety. 2.Correction for specific deficiency cited: On 5/16/18 resident #189 MD was contacted and notified of voicing feelings of depression and exhibiting signs of symptoms of anxiety. An order was received to refer resident #189 for mental health services NCPS and an order received for Xanax 0.5mg every 8hrs PRN for anxiety and this was discontinued on 5/21/18 and Valium 2.5mg BID PRN was ordered . Based on a root cause analysis by the Administrator that started on 5/15/18 the facility determined that resident # 189 was admitted to the facility on 4/25/18 with a history of asthma and Cerebral Palsy. According to Minimum data set with an assessment reference date of 5/2/18 which indicated that resident #189 had feelings of depression, was feeling tired and had a poor appetite, upon interview with this resident she did	

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F 600	Continued From page 5 An interview with the nursing assistant (NA#3) occurred on 5-16-18 at 10:10am and she stated that Resident #189 "cried a lot" and that the resident "seemed anxious." The NA stated when she observed those behaviors she reported them to the nurse. Resident #189 was observed on 5-17-18 at 9:40 where she was found to be fidgeting in her bed, eyes were darting around the room and she was complaining of not being able to breath. The nurse (#4) was interviewed on 5-17-18 at 9:43am and she stated the resident's oxygen level was at 98% and that Resident #189 "yells out all day she cannot breathe." The nurse went on to state she felt the resident was having "psychological" issues but denied that a mental health consultation was ever ordered. Nurse #4 also stated she had been informed by the nursing assistant of the resident crying at times and that she would talk with the resident and "try to help her." She stated she or the nurse manager could have spoken to the physician and obtained an order for a mental health consult. An interview with the Administrator occurred on 5-17-18 at 5:30pm who stated she expected her staff to follow the guidelines that were set by the Center for Medicare and Medicaid services and provide appropriate services to the residents.	F 600	indicate that she had not made anyone in the facility aware of the above. The social worker that documented the assessment on the 5/2/18 assessment is no longer employed. Interview with certified nursing assistants and Licensed Nurses that are assigned to the care of resident #189 on 5-16-2018 indicated that she does have periods of crying and complaining of not being able to breath. Upon review of MD history and physical dated 5/10/18 resident #189 denied anxiety and assessment indicated good air exchange and no respiratory issues. On 5/17/2018 Resident #189 was sent to the emergency room for evaluation of breathing and she was admitted and an Xray was performed that showed left lobe atelectasis. There is no documentation in the hospital records received for her 4/25/18 admission, 5/10/18 readmission or 5/19/2018 readmission regarding crying, feeling depressed, tired or having a loss of appetite. Resident #189 was seen by mental health services on 5/21/18 and was given a diagnosis of anxiety and no medication changes were done. Resident #189 will continue to be seen by Mental health services and there has been no documentation regarding feeling depressed, tired or loss of appetite. 3.The monitoring processes and systemic changes to ensure plan of correction is effective: Starting on 6/5/2018 the Social Services Director interviewed current residents with a BIMS score 8 or above to identify if	

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F 600	Continued From page 6	F 600	anyone showed any signs of needing a mental health referral.This information is documented on an interview tool and no other residents were identified for needing a mental health referral. Starting on 6-5-2018 the Social Services Director and Director of Nursing will complete re- education with current Certified Nursing Assistants and Licensed Nurses. This education will include signs and symptoms of depression and when and how to make a mental health referral. Certified Nursing Assistant or Licensed Nurse no re-educated prior to 6-5-2018 will not be allowed to work until re-education has occurred. Effective 6-5-2018 newly hired Certified Nursing Assistants and Licensed Nurses will receive education on signs and symptoms of depression and when and how to make a mental health referral. The Social services Director and Director of Nursing will monitor the compliance of identifying residents that need a mental health referral completing an interview audit with 5 residents with BIM scores 8 or above weekly times 4 weeks, then monthly times 3 months or until a pattern of compliance is maintained.Also, new admissions will be interviewed within the first 7 days. Effective 6-5-2018 the Social services Director and Director of Nursing will report the findings of the audits to the Quality Assessment and Assurance Committee (QAA)for any additional monitoring or modification of this plan monthly for 4 months or until a pattern of sustainable compliance is maintained. The Quality	

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F 600	Continued From page 7	F 600	Assessment and Assurance Committee (QAA)can modify this plan to ensure the facility remains in substantial compliance. 4. Effective 6-5-2018 the Administrator ,Director of nursing and Social Services director are responsible to ensure implementation of this plan of correction for this alleged noncompliance and to ensure the facility remains in substantial compliance.	
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete a significant change Minimum Data Set for 1 of 1 residents (resident #12) after the resident was placed on Hospice services. Findings included: Resident # 12 was admitted to the facility on	F 637	F 0637 1.Process that lead to the deficiency. The Minimum data set (MDS)assessments named were incorrect due to MDS nurse not gathering correct information and investigating the data required to do an accurate assessment on	6/5/18

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F 637	Continued From page 8 11-29-17 with multiple diagnoses that included atrial fibrillation, difficulty walking, muscle weakness and Alzheimer's. The Minimum Data Set (MDS) dated 4-3-18 revealed that resident #12 was severely cognitively impaired and that she was not on Hospice services. The care plan dated 4-17-18 for resident #12 revealed a goal that the resident would have her wishes and advanced directives honored. The following was the intervention; allow resident and family to vent their feelings, notify physician and hospice for potential changes or need for treatment, provide comfort measures and provide resident and family privacy as needed. A review of the physician's orders revealed that resident #12 was admitted to Hospice on 12-18-17. The medical record for resident #12 revealed that the resident was seen by a Hospice nurse weekly and a Hospice aide 2 times a week. An interview with the nursing assistant (NA #1) occurred on 5-16-18 at 2:57pm and she stated that a Hospice aide came to provide care for resident #12 on Wednesdays and Fridays. She went on to state that the nursing assistant assigned to resident #12 provided care for her when the Hospice aides were not available. The MDS nurse was interviewed on 5-16-18 at 4:45pm who stated she was not employed at the time the significant change MDS assessment should have been completed for resident #1 to reflect Hospice services were being received, so	F 637	the residents. 2.correction for specific deficiency The Director of Nursing and or designee will complete an audit on 5/22/2018 of all current residents receiving assessments on admission, annual, significant change or on Hospice services and to include quarterly assessment during the last 30 days to verify accurate coding of the MDS per the resident assessment guidelines. Resident #12, will require modifications,The modifications were completed on 5/16/18. Resident #12 will require a significant change assessment correction of prior comprehensive assessment and the modifications will be completed by the resident care management director and or MDS designee per the resident assessment guidelines.The modifications were completed by MDS nurse and submitted and accepted on 5/16/2018. 3.The monitoring processes and systemic changes to ensure plan of correction is effective The Regional Director of care Management reeducated the interdisciplinary team and MDS coordinator on accurate coding of pertinent medical diagnosis, and accurate completion of MDS assessments. The education was completed on 5/18/2018. 4.The Administrator and the Director of nursing along with Interdisciplinary team will review 5 completed mds assesments	

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F 637	Continued From page 9 she was not able to provide any information as to why it was not completed. An interview with the Administrator occurred on 5-17-18 at 5:30pm who stated she expected her staff to follow the guidelines that were set by the Center for Medicare and Medicaid services.	F 637	weekly x 4 weeks,then monthly x 3 months to verify accurate completion and coding of the mds, making any corrections as necessary. 5.The results of these audits, will be monitored to ensure on going compliance, data collection to be analyzed and reviewed at monthly Quality Assessment and Assurance Committee (QAA)meeting x 3 months with subsequent POC as needed.The Nursing Home Administrator and Don are responsible to maintain and follow this plan of correction.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately assess Hospice services (Resident #12), oxygen use (Resident #189) and Dialysis services (Resident #7) for 3 of 6 sampled residents. Findings included: 1: Resident # 12 was admitted to the facility on 11-29-17 with multiple diagnoses that included Alzheimer's disease. The Minimum Data Set (MDS) dated 4-3-18 revealed that Resident #12 was not coded as being on Hospice services.	F 641	F0641 1.process that led to deficiency: The Minimum data set (MDS)assessments named were incorrect due to MDS nurse not gathering correct information and investigating the data required to do an accurate assessment on the residents. The Director of Nursing and or designee will complete an audit on 5/30/2018 of all current residents receiving assessments on admission, annual, significant change or on Hospice services and t include quarterly assessment during the last 30	6/5/18

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F 641	Continued From page 10 Resident #12's care plan dated 4-17-18 documented goals and interventions reflecting Hospice services. A review of the physician's orders revealed that Resident #12 was admitted to Hospice on 12-18-17. The medical record reviewed for Resident #12 during the dates of 3-1-18 to 5-17-18 revealed that the resident was seen by a Hospice nurse weekly and a Hospice aide 2 times a week. During an interview on 5-16-18 at 4:45pm, the MDS nurse stated she "just missed it" and that hospice should have been coded for the resident on the 4-3-18 MDS. The Administrator was interviewed on 5-17-18 at 5:30pm and stated she expected her staff to follow the guidelines that were set by the Center for Medicare and Medicaid services. 2: Resident #189 was admitted to the facility initially on 4-25-18 and then readmitted 5-10-18 after a 5-day hospital stay. Resident #189 was admitted to the facility with multiple diagnoses which included chronic obstructive pulmonary disease. The Minimum Data Set (MDS) dated 5-2-18 revealed that Resident #189 was mildly cognitively impaired and was not coded as having received oxygen therapy. The care plan dated 5-15-18 did not reveal any goals or interventions for oxygen use. Review of nursing summary dated 4-28-18 revealed Resident #189 used 2 liters of oxygen	F 641	days to verify accurate coding of the MDS per the resident assessment guidelines. 2.correction for specific deficiency sited Resident #12, resident #189 and resident # 7 will require modifications for the admission assessments with ard date. The modifications were completed on 5/16/18,5-17-2018,and 6-5-2018. Resident #12 will require a significant change assessment correction of prior comprehensive assessment and the modifications will be completed by the resident care management director and or MDS designee per the resident assessment guidelines. Resident # 189 will require a modification to her initial admission assessment which was completed and accepted 6-5-2018. Resident#7initial admit assessments, and any following assessments will be modified to display the correct information to include this resident as receiving dialysis treatments. The modifications were completed by MDS nurse and submitted and accepted on 6/5/2018. 3.The monitoring processes and systemic changes to ensure the plan of correction is effective. The Director of Nursing reeducated the interdisciplinary team and MDS coordinator on accurate coding of pertinent medical diagnosis, and accurate completion of MDS assessments. The education was completed on 6/5/2018. The Administrator and the Director of	

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F 641	Continued From page 11 using a nasal cannula. In an interview on 5-17-18 at 8:30am, the Director of Nursing (DON) stated resident #189 "has always been on oxygen" since the resident was admitted. During an interview on 5-16-18 at 9:00am, Resident #189 stated she had been wearing oxygen for "a long time." In an interview on 5-17-18 at 5:30pm, the Administrator stated she expected her staff to follow the guidelines that were set by the Center for Medicare and Medicaid services. 3: Resident #7 was admitted to the facility on 2-22-18 with multiple diagnoses that included dependence on renal dialysis. The Minimum Data Set (MDS) dated 3-1-18 revealed that the resident was cognitively intact and not coded for Dialysis. A review of the physician orders revealed that Resident #7 was started on Dialysis 2-22-18. Resident #7's nurse's notes were reviewed from 2-26-18 to 5-17-18 which revealed that Resident #7 was receiving dialysis Monday, Wednesday and Fridays. In an interview on 5-17-18 at 11:02am, the MDS nurse stated she was not the one who completed the assessment but that resident #7 should have been coded for Dialysis treatment. During an interview with the Administrator on 5-17-18 at 5:30pm she stated she expected her staff to follow the guidelines that were set by the	F 641	nursing along with Interdisciplinary team will review 5 completed mds assesments weekly x 4 weeks,then monthly x 3 months to verify accurate completion and coding of the mds, making any corrections as necessary. 4.The results of these audits, will be monitored to ensure on going compliance, data collection to be analyzed and reviewed at monthly Quality Assessment and Assurance Committee (QAA) meeting x 3 months with subsequent POC as needed.The Nursing Home Administrator and Don are responsible to maintain and follow this plan of correction.	

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F 641	Continued From page 12 Center for Medicare and Medicaid services.	F 641		
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 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	F 656		6/5/18

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F 656	Continued From page 13 local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, resident interviews and observations the facility failed to follow the care plan for assistance with activities of daily living (ADL) for 1 of 1 residents reviewed for bathing (Resident #7) and the facility failed to develop care plans for assistance with ADL (Resident #188), and incontinence and pain management (Resident #21) for 3 of 3 sampled residents. Findings included: Resident #7 was admitted to the facility on 2-22-18 with multiple diagnoses that included a urinary tract infection, muscle weakness, diabetes. The significant change Minimum Data Set (MDS) dated 3-1-18 revealed that Resident #7 was cognitively intact and needed extensive assistance of 2 people for bed mobility, dressing and personal hygiene, total assistance of 2 people for transfers and locomotion on and off the unit, extensive assistance of one person for toileting and total assistance of 2 people for bathing. Resident #7's care plan for ADL's dated 3-19-18 revealed a goal that she would improve her current level of functioning in all ADL's. The following were the interventions; resident was	F 656	F 656 Develop/Implement Comprehensive Care Plans 1. Process that lead to the deficiency: The alleged noncompliance occurred when NA #3 failed to follow the care plan for resident #7 which indicated 2 people were needed for bathing. When the MDS nurse failed to develop a care plan for assistance with ADL□s for resident #188 and failed to develop a care plan for incontinence and pain management for resident #21. 2. Correction for specific deficiency cited: NA #3 is no longer employed and MDS nurse is no longer employed. On 6-5-2018 the current Director of Nursing re-educated the current certified nursing assistants to follow the care plan for resident #7 which indicated 2 people were needed for bathing. On 6-5-2018 the current MDS coordinator reviewed and revised the current care plan for resident # 188 to reflect the assistance needed for ADLS and she reviewed and revised resident #21 care plan to reflect incontinence and pain management.	

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F 656	Continued From page 14 totally dependent on 2 staff to provide bed bath/shower, resident preferred to be repositioned by 2 people. A review of Resident #7's care card for the nursing assistant revealed that the resident was to be provided a bed bath with 2 people assisting. An observation of ADL care with Resident #7 was completed on 5-17-18 at 9:20am. NA #3 was noted to provide a bed bath by herself to Resident #7 and allowed the resident time to participate in her own care, however, the NA and the resident had a difficult time turning as the resident was not able to turn herself from side to side and the NA did not have help to turn her. The resident was noted to make a grimacing face while being turned. NA #3 was interviewed on 5-17-18 at 9:20am and stated she was aware that the care card stated 2 people should assist with bathing Resident #7 but felt that she did not need 2 people "I always bath her by myself but if I needed help there was enough staff to help me." Resident #7 was interviewed on 5-17-18 at 10:46am and stated she "usually" only had one NA giving her a bed bath. She also stated she would prefer 2 people to help because it was hard for her to turn on her own and stay on her side for a long time without someone holding her over. In an interview on 5-17-18 at 5:30pm, the Administrator stated she expected her staff to follow the care plan. 2: Resident #188 was admitted to the facility on 3-27-18 with multiple diagnosis which included	F 656	3. The monitoring processes and systemic changes to ensure plan of correction is effective: On 6-5-218 the Director of Nursing and MDS coordinator completed an audit of residents currently in the facility. The audit tool identified residents receiving assistance with either ADL□s, incontinent care,and that receive pain management. Care plans were reviewed and revised to indicate assistance with ADL□s, incontinence and pain management for 2 residents that were identified. On 6-5-2018 the regional MDS Coordinator educated the current MDS coordinator on the requirements for developing a care plan and a process of reviewing new admissions and physician orders daily Monday thru Friday to identify those residents that need assistance with ADL□s, that are incontinent or receiving pain management to ensure that the current care plan is reflective of the residents current status and that these changes are communicated via point of care to the certified nursing assistants. The Director of nursing and the administrator will monitor the compliance of developing care plans on residents that require assistance with ADL□s, that are incontinent or receiving pain management by auditing current residents care plans monthly times 3 months or until a pattern of compliance is maintained. The Director of Nursing services will	

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F 656	Continued From page 15 hyperosmolarity, acute kidney failure, pressure ulcer, hydro nephrosis, and cerebral palsy. The admission Minimum Data Set (MDS) dated 4-3-18 revealed that Resident #188 needed extensive assistance of 2 people for bed mobility and transfers, total assistance of one person for dressing and extensive assistance of one person for eating, toileting and personal hygiene. A review of the medical record for Resident #188 revealed there were no care plans that addressed activities of daily living. The care area assessment dated 4-9-2018 revealed that Resident #188 was to be care planned for activities of daily living due to his decline in physical functioning, cerebral palsy and contractures of his upper and lower limbs. Nursing Assistant (NA) #3 was interviewed on 5-16-18 at 11:50am. The NA stated she did not have a care plan/care card for ADL care for Resident #188 "I just give him the same care I give everyone." An interview with the MDS Nurse occurred on 5-17-18 at 2:36pm and she stated she completed Resident #188's 4-3-18 admission MDS but did not know why there was not a care plan for Resident #188 that addressed ADL care. She also stated "I thought I did a care plan. I must have missed it." An interview with the Administrator occurred on 5-17-18 at 5:30pm who stated she expected her staff to develop and follow the care plan. 3: Resident #21 was admitted to the facility 4/6/18 with the diagnoses of hypertension (high	F 656	monitor certified nursing assistants by observation 3 times week for 2 weeks, then weekly for 3 months to ensure the care plan for each resident regarding assistance needed for bathing is being followed. Effective 6-5-2018 the MDS Coordinator and director of nursing will report the findings of the audits and observations to the Quality Assessment and Assurance Committee (QAA) for any additional monitoring or modification of this plan monthly for 3 months or until a pattern of sustainable compliance is maintained. The Quality Assessment and Assurance Committee (QAA)can modify this plan to ensure the facility remains in substantial compliance. 4. Responsible Party: Effective 6-5-2018 the MDS coordinator and Director of Nursing services are responsible to ensure implementation of this plan of correction for this alleged noncompliance and to ensure the facility remains in substantial compliance.	

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F 656	Continued From page 16 blood pressure), hip fracture, non-Alzheimer's dementia, and COPD. The quarterly Minimum Data Set (MDS) dated 4/20/18 indicated Resident #21 had severe cognitive impairment, no behaviors, and no rejection of care. Resident #21 required one to two person extensive assistance with bed mobility, transfers, dressing, toilet use, personal hygiene, locomotion on/off unit, and supervision for eating meals. The resident was frequently incontinent of bladder and always incontinent of bowel, on a scheduled pain medication regimen, received PRN (as needed) pain medication, and was administered diuretics 7 out of 7 days and opioids 5 out of 7 days during that assessment period. Review of the most recent Care Area Assessment (CAA) dated for 4/13/18 revealed that the facility identified triggered care areas for urinary incontinence and indwelling catheter and pain. Resident #21's active care plan/care card reviewed on 5/17/18 revealed that there was no care plan in place for pain or incontinence. During an interview with the DON on 5/17/18 at 4:02 PM, she stated that anyone prescribed pain medications or required assistance with incontinence care should have a care plan in place for those areas. During an interview with the Administrator on 5/17/18 at 6:28 PM, she stated that care plans are expected to address each resident's individual needs and should be carried out by staff accordingly.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		6/6/18

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F 677	Continued From page 17 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to provide timely transfer assistance from wheelchair to bed for 1 of 2 residents reviewed for activities of daily living (ADLs) (Resident #36). The findings included: 1. Resident #36 was admitted to the facility 4/10/18 with the diagnoses of anemia, hypertension, and diabetes. The Admission Minimum Data Set (MDS) dated 4/17/18 indicated Resident #36 had no cognitive impairment, no behaviors, and no rejection of care. Resident #36 required one to two person extensive assistance with bed mobility, transfers, toileting, and personal hygiene. The resident's active care plan stated she had an ADL self-care performance deficit related to activity intolerance and fatigue. During an interview on with Resident #36 on 5/14/18 7:02 PM the resident was found in her room beside her bed in her wheel chair. She stated she had asked staff for assistance to transfer to her bed at approximately 5:00 PM, but had not received assistance yet. Resident #36 stated that the longer she sat in her wheelchair the stiffer her body would get and that she hated asking staff to help her because if she was stiff and not able to help, they would get frustrated	F 677	F 0677 Adl care provided for dependent residents 1.The Process that lead to the deficiency: The alleged noncompliance occurred when NA #1 did not provide ADL assistance in a timely manner for resident #36.The resident needed assistant to transfer from their wheelchair to the bed on May 14th during the 3 to 11 shift. 2.Correction for specific deficiency cited: Resident # 36 was assisted to transfer from the wheelchair to bed at 740 pm on May 14th 2018. The Director of Nursing on 5-14-2018,when notified, accessed resident # 36 for any sighs and symptoms of skin break down, and problems with range of motion. The director of nursing also ask the resident if she was in pain at that time, The resident stated she was ok and was not in pain at this time. NA#1 was re-educated on ADL care and providing timely assistance when a resident request to be transferred from their wheelchair to the bed. 3.The monitoring processes and systemic	

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F 677	Continued From page 18 with her. During an interview on 5/14/18 at 7:15 PM the resident's Nurse Assistant (NA #1) came into the room. When this surveyor asked the NA if she could help the resident back to bed, the NA stated that she had been waiting on her partner to help transfer Resident #36 to her bed, and then walked out of the room. During an observation on 5/14/18 at 7:40 PM two NAs were observed moving Resident #36 to her bed. During an interview with the Administrator on 5/17/18 at 6:20 PM, she stated that it was her expectation for staff to address residents' requests in a timely manner and to maintain the resident's dignity while performing daily tasks. When asked about the observation and the amount of time it took staff to transfer the resident to her bed, she stated that was too long to have to wait for assistance.	F 677	changes to ensure plan of correction is effective: Starting on 6/6/18 to the Director of Nursing services interviewed current residents with a BIMS score of 8 and above to identify if they are assisted timely when assistance is requested to transfer from wheelchair to bed. The director of nursing also did a assessment on all residents with a bims score less than 8 to ensure there was no skin breakdown due to the deficient practice. This information is documented on an interview tool and on skin assessment sheets. There were no other residents that were identified for not receiving timely assistance when requested to transfer from wheelchair to bed. Starting on 6/6/2017 the Director of Nursing services will complete re-education with current Certified Nursing Assistants and Licensed Nurses. This education will include timely assistance for residents who require ADL assistance and who request to transfer from their wheelchair to the bed. Any Certified Nursing Assistant or Licensed Nurse not re-educated prior to 6/6/2018 will not be allowed to work until re-education has occurred. Effective 6-6-2018 newly hired Certified Nursing Assistants and Licensed Nurses will receive education on timely transfers and ADL assistance for residents who request to transfer from the wheelchair to bed. The Director of Nursing services will monitor the compliance of assisting	

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F 677	Continued From page 19	F 677	residents who request assistance to transfer from their wheelchair to bed by completing an interview audit with 5 residents with BIM scores 8 or above daily times 14 days, then weekly times 4 weeks, then monthly times 3 months or until a pattern of compliance is maintained. Effective 6-6-2018 the Director of Nursing Services will report the findings of the audits to the Quality Assessment and Assurance Committee (QAA)for any additional monitoring or modification of this plan monthly for 5 months or until a pattern of sustainable compliance is maintained. Quality Assessment and Assurance Committee (QAA)can modify this plan to ensure the facility remains in substantial compliance. 4. Effective 6-6-2018 the Administrator and Director of Nursing Services are responsible to ensure implementation of this plan of correction for this alleged noncompliance and to ensure the facility remains in substantial compliance.	
F 742 SS=G	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the	F 742		6/5/18

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F 742	Continued From page 20 assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and resident interview the facility failed to provide mental health services for 1 of 1 residents (Resident #189) who voiced feelings of depression and exhibited signs and symptoms of anxiety. Findings included: Resident #189 was admitted to the facility initially on 4-25-18 and then readmitted 5-10-18 after a 5-day hospital stay. Resident #189 was admitted to the facility with multiple diagnoses which included neuromuscular dysfunction, tremors, enter colitis, asthma, chronic obstructive pulmonary disease. The Minimum Data Set (MDS) dated 5-2-18 revealed that resident #189 was moderately cognitively intact and had feelings of depression 12-14 days, feeling tired 7-11 days and a poor appetite 7-11 day. The care plan dated 5-15-18 did not reveal any goals or interventions for mental health services. During an interview with Resident #189 on 5-15-18 at 10:21am she expressed feeling "helpless" because she was no longer as independent. The resident was tearful and stated she cried every day. She denied speaking to anyone about her feelings since she was admitted to the facility. The MDS nurse was interviewed on 5-15-18 at 10:30am and she stated the resident should have	F 742	F 742 Treatment/Services Mental/Psychosocial Concerns 1. Process that lead to the deficiency: The alleged noncompliance occurred when Resident #189 did not receive mental health services after voicing feelings of depression and exhibiting signs of symptoms of anxiety. 2. Correction for specific deficiency cited: On 5/16/18 resident #189 MD was contacted and notified of voicing feelings of depression and exhibiting signs of symptoms of anxiety. An order was received to refer resident #189 for mental health services NCPS and an order received for Xanax 0.5mg every 8hrs PRN for anxiety and this was discontinued on 5/21/18 and Valium 2.5mg BID PRN was ordered . Based on a root cause analysis by the Administrator that started on 5/15/18 the facility determined that resident # 189 was admitted to the facility on 4/25/18 with a history of asthma and Cerebral Palsy. According to Minimum data set with an assessment reference date of 5/2/18 which indicated that resident #189 had feelings of depression, was feeling tired and had a poor appetite, upon interview with this resident she did indicate that she had not made anyone in	

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F 742	Continued From page 21 been care planned for mental health services by the Social Worker. Resident #189's medical record did not reveal any order or consultation for mental health services. An interview with the nursing assistant (NA#3) occurred on 5-16-18 at 10:10am and she stated that Resident #189 "cried a lot" and that the resident "seemed anxious." The NA stated when she observed those behaviors she reported them to the nurse. In an interview on 5-16-18 at 12:00pm, the Social Worker stated she just started at the facility and was unaware of the resident's issues but that she would talk with the resident. Resident #189 was observed on 5-17-18 at 9:40 where she was found to be fidgeting in her bed, eyes were darting around the room and she was complaining of not being able to breath. The nurse (#4) was interviewed on 5-17-18 at 9:43am and she stated the resident's oxygen level was at 98% and that Resident #189 "yells out all day she cannot breathe." The nurse went on to state she felt the resident was having "psychological" issues but denied that a mental health consultation was ever ordered. Nurse #4 also stated she had been informed by the nursing assistant of the resident crying at times and that she would talk with the resident and "try to help her." She stated she or the nurse manager could have spoken to the physician and obtained an order for a mental health consult. An interview with the Administrator occurred on	F 742	the facility aware of the above. The social worker that documented the assessment on the 5/2/18 assessment is no longer employed. Interview with certified nursing assistants and Licensed Nurses that are assigned to the care of resident #189 on 5-16-2018 indicated that she does have periods of crying and complaining of not being able to breath. Upon review of MD history and physical dated 5/10/18 resident #189 denied anxiety and assessment indicated good air exchange and no respiratory issues. On 5/17/2018 Resident #189 was sent to the emergency room for evaluation of breathing and she was admitted and an Xray was performed that showed left lobe atelectasis. There is no documentation in the hospital records received for her 4/25/18 admission, 5/10/18 readmission or 5/19/2018 readmission regarding crying, feeling depressed, tired or having a loss of appetite. Resident #189 was seen by mental health services on 5/21/18 and was given a diagnosis of anxiety and no medication changes were done. Resident #189 will continue to be seen by Mental health services and there has been no documentation regarding feeling depressed, tired or loss of appetite. 3. The monitoring processes and systemic changes to ensure plan of correction is effective: Starting on 5-16-18 the Social Services Director interviewed current residents with	

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F 742	Continued From page 22 5-17-18 at 5:30pm who stated she expected her staff to follow the guidelines that were set by the Center for Medicare and Medicaid services and provide appropriate services to the residents.	F 742	a BIMS score 8 or above to identify if anyone showed any signs of needing a mental health referral. This information is documented on an interview tool and no other residents were identified for needing a mental health referral. Starting on 5-16-2018 the Social Services Director will complete re- education with current Certified Nursing Assistants and Licensed Nurses. This education will include signs and symptoms of depression and when and how to make a mental health referral. Certified Nursing Assistant or Licensed Nurse no re-educated prior to 6-5-2018 will not be allowed to work until re-education has occurred. Effective 6-5-2018 newly hired Certified Nursing Assistants and Licensed Nurses will receive education on signs and symptoms of depression and when and how to make a mental health referral. The Social services Director will monitor the compliance of identifying residents that need a mental health referral completing an interview audit with 5 residents with BIM scores 8 or above weekly times 4 weeks, then monthly times 3 months or until a pattern of compliance is maintained. new admissions will be interviewed within the first 7 days. Effective 6-5-2018 the Social services Director will report the findings of the audits to the Quality Assessment and Assurance Committee (QAA) for any additional monitoring or modification of this plan monthly for 3 months or until a pattern of sustainable compliance is maintained. The Quality Assessment and	

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F 742	Continued From page 23	F 742	Assurance Committee (QAA)can modify this plan to ensure the facility remains in substantial compliance. 4. Responsible Party: Effective 6-5-2018 the Administrator and Social Services director are responsible to ensure implementation of this plan of correction for this alleged noncompliance and to ensure the facility remains in substantial compliance.	
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interviews, the facility provided a resident with milk on two occasions when the resident had allergies to milk and was lactose intolerant as defined on his care plan in one out of one resident (Resident #5) who had a documented food allergy. Resident #5 was admitted to the facility on 10/25/17 with diagnoses that included heart	F 806	F 806 Resident Allergies, Preferences, Substitutes 1. Process that lead to the deficiency: The alleged noncompliance occurred when resident #5 received milk on two occasions when the resident #5 had allergies to milk and was lactose intolerant as defined on the care plan. The dietary	6/5/18

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F 806	Continued From page 24 failure, hypertension, and atrial fibrillation. A review of Resident #5's medical record revealed on admission 10/25/17 milk and lactose intolerance was listed under allergies. A review of Resident #5's most recent quarterly MDS (Minimum Data Set) assessment dated 5/11/18 revealed the resident is without cognitive impairment. The MDS revealed Resident #5's active diagnoses included anemia, heart failure, hypertension, atrial fibrillation, muscle weakness, gastroesophageal reflux disease, and chronic kidney disease stage 3. A review of Resident #5's care plan dated 11/2/17 revealed the care plan addressed the resident's allergy to milk and stated the staff was to provide and serve a diet as ordered and determine the individual likes and dislikes. A review of Resident #5's medical record revealed a food preference interview dated 3/30/18. Resident #5's food preference reported under food allergies that the resident was allergic to milk. The food preference record also revealed Resident #5 preferred orange juice for breakfast and water and iced tea as beverages for lunch and dinner. An interview with Resident #5 was conducted on 5/14/18 at 6:46pm. Resident #5 reported that on 5/13/18 he was given 2% milk with breakfast and dinner. He reported he told the staff he could not drink milk and was told that was all the kitchen had to give him. He said the staff told him that they were out of juices and other drinks. He reported that he gave his milk to his roommate and just drank water as he could not drink milk due to being lactose intolerant. An interview with the regional dietary manager was conducted on 5/17/18 at 2:42pm. The regional dietary manager reported a food preference interview is done on each resident on	F 806	staff failed to follow residents dietary meal preferences and accommodations for allergies. 2. Correction for specific deficiency cited: On 5-14-2018 resident #5 was interviewed by the Director of nursing services and dietary manager to determine drink preferences during meals. The Director of dietary services re-educated current dietary staff on following the tray card and provide the liquids that are included on the tray card and to not provide those liquids that show as an allergy. On (date) the Director of nursing re-educated the certified nursing assistants to read the tray card upon to delivery to the resident and if the liquids are incorrect remove them and obtain liquids of choice for the resident. 3. The monitoring processes and systemic changes to ensure plan of correction is effective: On 5-18-2018 the current dietary manager interviewed current residents with a BIMS score of 8 or higher to review preferences and 4 preferences were updated. Starting on 5-18-2018 the dietary manager will complete re-education with current dietary staff on how to read the tray card for preferences and allergies regarding beverages. Starting on 6-5-2018 The Director of Nursing services will re-educate the certified nursing assistants and licensed nurses on	

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F 806	Continued From page 25 admission and as requested or with a diet change. He reported that on Resident #5's dietary sheet it is listed that the resident is allergic to milk and lactose intolerant. He reported he does not know why Resident #5 was given milk on 2 separate occasions on 5/13/18. He reported it is his expectation that all food allergies and preferences will be honored on every resident at every meal. An interview was conducted on 5/17/18 at 5:30pm with the administrator. She reported it is her expectation that the dietary staff will provide meals to the residents that take into consideration any food allergies and preferences.	F 806	honoring drink preferences per the tray card and ensuring residents so not receive beverages that are stated as an allergy. This education will include how to read the tray cards for drink preferences and allergies. Dietary staff, Certified Nursing Assistant or Licensed Nurse not re-educated prior to 6-5-2018 will not be allowed to work until re-education has occurred. Effective 6-5-2018 newly hired dietary staff, Certified Nursing Assistants and Licensed Nurses will receive education on how to read the tray cards for preferences and allergies regarding beverages. The Dietary manger will monitor the compliance of residents receiving beverages of choice by completing an interview audit with 5 residents with BIM scores 8 or above weekly for 4 weeks, then monthly times 3 months or until a pattern of compliance is maintained.Also, new admissions will be interviewed within the first 7 days. The Director of Nursing services will audit by observation to ensure residents are receiving beverages of choice as reflected on the tray card for 5 residents weekly for 4 weeks, then monthly for 3 months or until a pattern of compliance is maintained Effective 6-5-2018 the dietary manger will report the findings of the audits to the Quality Assessment and Assurance Committee (QAA) for any additional monitoring or modification of this plan monthly for 3 months or until a pattern of sustainable compliance is maintained. The Quality Assessment and Assurance Committee (QAA) can modify this plan to	

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F 806	Continued From page 26	F 806	ensure the facility remains in substantial compliance. 4. Responsible Party: Effective 6-5-2018 the Administrator and dietary manger are responsible to ensure implementation of this plan of correction for this alleged noncompliance and to ensure the facility remains in substantial compliance.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to provide soap and paper towels at	F 812	F812 Food safety requirements 1. Process that lead to deficiency:	6/5/18

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F 812	Continued From page 27 the hand sinks in the kitchen, failed to ensure foods were sealed, labeled and dated when stored, failed to discard food that was expired and failed to allow dishes, cookware and storage containers to air dry. Findings included: 1. During the initial tour of the kitchen on 5-14-18 at 6:15pm the following items were identified: a. There was no soap available at the first hand sink and no paper towels available at the second hand sink. b. There were 19 metal pans stacked on top of each other still wet, 5 plastic plate lids stacked on top of each other wet and 16 plastic containers stacked on top of each other wet. All items were on the storage shelf ready to be used. c. The reach in refrigerator had a plastic bag of shredded yellow cheese not dated and a block of butter that was open, exposed to the air laying in an open cardboard box not sealed. d. The bread rack next to the tray serving line had 10 hot dog buns with a best buy date of 4-20-18 and the buns were noted to be dry and cracking. There were 5 hot dog buns with a best buy date of 3-3-18 and the buns were noted to be dry and crumbling. There were 6 hamburger buns that were open, not sealed or dated and those buns were dry and cracking. e. The dry storage room revealed approximately one bowel of cheerios open, exposed to the air, in a plastic bag with no date, a 5lb bag of grits was open, exposed to the air, and not sealed, a small bag of spiral noodles was	F 812	a. During the initial tour of the kitchen the following concerns were observed: There was no soap at sink 1 and no paper towels at sink,Metal Pans, plastic lids and containers were stacked wet and unable to air dry. The Reach in cooler had cheese and butter not properly dated or sealed,Bread rack had buns that were outdated and not properly sealed,The dry storage room had cereal, grits, and noodles that were not properly sealed or dated.The walk in cooler had expired dressing as well as eggs, mayo and cheese not properly dated.The walk in freezer had ground beef, okra, carrots, broccoli, and beef patties that were not properly sealed and dated,Ceramic bowls were stacked wet next to the tray line. Correction for specific deficiency cited: The follow actions took place at the time of observation i. Soap and paper towels were refilled ii. Metal pans, plastic lids and containers were rewashed and properly placed on shelf to air dry iii. Cheese and butter were discarded iv. All outdate and improperly sealed bread was discarded v. Grits, cereal, and noodles were discarded vi. Eggs mayo and cheese were discarded vii. Beef, okra, carrots, broccoli, and beef patties were discarded,The follow actions took place at the time of observation,Ceramic bowls were rewashed and properly air dried 3.The monitoring processes and systemic	

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F 812	Continued From page 28 open, exposed to the air and not sealed or dated and a bag of tube noodles was open, exposed to the air not sealed or dated. f. The walk-in refrigerator had an open container of French dressing with an expiration date of 11-7-17, half a box of pre-cooked eggs was opened, exposed to the air, not sealed or dated, a container of mayonnaise opened not dated and a plastic bag of white shredded cheese with a use by date of 4-24-18. g. The walk-in freezer was found to have a half roll of hamburger meat opened and not dated, a box of okra, half a box of carrots, half a box of broccoli and half a box of meat patties that were open, exposed to the air, not sealed or dated. In an interview on 5-14-18 at 6:45pm with dietary staff he stated he was aware of the issues but that he had been on leave for the past 21 days and that he did not have any explanation for the issues that were found. During an interview on 5-14-18 at 8:00pm with the Dietary Manager he stated he had just started working at the facility 3 weeks ago and was aware of some of the issues. 2. An observation of the kitchen occurred on 5-15-18 at 11:20am and it was noted there were 20 ceramic bowels stacked next to the tray line available for service of the lunch meal that were wet. In an interview on 5-15-18 at 11:22am with the dietary manager he stated he would remove the bowels and replace them with new ones.	F 812	changes to ensure plan of correction is effective Monitoring tools were put in place 5-18-18 to address each deficient practice. In-servicing began on 5-18-18. Dietary Aides will sign off on a monitoring tool each shift noting that all hand washing stations are properly stocked, small wares are properly air dried, items in the dry storage room, reach-in cooler and bread rack are properly dated and sealed for 6 weeks. The dietary manager will sign off each day to assure compliance. Dietary Cooks will sign off on a monitoring tool each shift noting all pans, lids and containers are properly air dried, all items in the walk-in cooler and freezer and properly sealed and dated daily for 6 weeks, then weekly x 4 weeks, then monthly x 3 months to ensure on going compliance. The dietary manager will sign off each day to assure compliance. The dietary manager will complete a monitoring tool 5 times a week noting that all small wares are properly air dried, all food items are properly sealed and dated, and all hand washing stations are properly stocked for 6 weeks. The district manager will complete a monitoring tool once a week noting that all small wares are properly air dried, all food items are properly sealed and dated, and all hand washing stations are properly stocked for 6 weeks. All dietary staff will be in-serviced weekly for 6 weeks on proper food storage, air drying small wares and properly stocking hand washing stations. The director of dietary Services will report	

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F 812	Continued From page 29 During an interview on 5-16-18 at 2:00pm with the Dietary Manager and Regional Manager, they stated they were aware of the issues and that they were planning in-services with the staff on proper dietary procedures. The Administrator was interviewed on 5-17-18 at 5:30pm and she stated she expected the dietary staff to follow their guidelines.	F 812	the findings of the audits to the Quality Assessment and Assurance Committee (QAA) for any additional monitoring or modification of this plan monthly for 3 months or until a pattern of sustainable compliance is maintained. The Quality Assessment and Assurance Committee (QAA) can modify this plan to ensure the facility remains in substantial compliance. 4. Effective 6-6-2018 the Administrator and Director of Nursing Services are responsible to ensure implementation of this plan of correction for this alleged noncompliance and to ensure the facility remains in substantial compliance.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility's Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor interventions that the committee put into place following the 3/14/2018 complaint survey. This was for a recited deficiency in the area of Accuracy of Assessments (F641). The deficiency was cited again on the current recertification and revisit survey on 5/17/2018. The continued failure of the facility during two federal surveys of record	F 867	F-867 Quality assessment and assurance 1.Process that lead to the deficiency: The facility failed to accurately assess Hospice services, oxygen use, and Dialysis services, identification of trends or patterns, submission of data, and initiation of quality improvement plans related to identified areas of opportunity.	6/5/18

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F 867	Continued From page 30 shows a pattern of the facility's inability to sustain an effective QAA program. Findings include: This tag is cross referenced to: F641- Accuracy of Assessments: Based on record review and staff interviews the facility failed to accurately assess Hospice services (Resident #12), oxygen use (Resident #189) and Dialysis services (Resident #7) for 3 of 6 sampled residents. During the complaint survey on 3/14/2018 failed to accurately code the MDS (Minimum Data Set) to include the active diagnoses on 3 of 3 residents reviewed for medication errors. On the current recertification and follow-up survey of 5/17/2018, the facility failed to accurately assess Hospice services, oxygen use, and Dialysis services. An Interview was conducted with the facility's Administrator on 5/17/2018 at 6:17 PM. When asked who attends the meeting she stated that the Administrator, DON, ADON, Social Worker, the medical director attended, as well as all of the other department heads. The meetings were held every month and as needed, and the committee reviewed problems and concerns found in the facility. She stated that the facility had recently undergone a change in management, and that ongoing observations were being completed daily to indicate changes that needed to be made. Once things were identified, interventions were being implemented to correct problem areas put into place from the previous management team. When asked what expectations the facility's administration had for	F 867	2. On 5-22-2018,The Director of Clinical Services conducted re-education for the Administrator on the facility's Quality Assessment and Assurance Committee (QAA) Program including accurately coding the MDS (Minimum Data Set) to include the active diagnoses on residents. All members of the Quality Assessment and Assurance Committee (QAA)submit data related to each department and participate in the identification of areas in need of improvement. 3. The Administrator and the Director of Nursing will present the results of all audits of transcription of physician□s orders, audits of MDS assessments,care plans, to the Quality Assessment and Assurance (QAA)committee weekly for four (4) weeks and then monthly thereafter. The next Quality Assessment and Assurance Committee (QAA)meetings will be conducted weekly for four weeks, then monthly with oversight by District Director of Clinical Services for three months 4. Measures to ensure that corrections are achieved & sustained include: the Director of Nursing will present the information obtained via the audits and observations. The committee will amend the plan based on identified audit trends. These amendments will be implemented immediately following the meeting, to include progressive discipline, re-education and additional monitoring to	

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F 867	Continued From page 31 preventing reoccurring problems, specifically with accuracy of MDS assessments, she stated the expectation was that changes would be made throughout the facility to verify the MDS coordinator had any and all pertinent information that was required for each individual resident assessment, so that it would be completed accurately.	F 867	address opportunities as identified weekly for 4 weeks then monthly for 3 months subsequent POC as needed. 5. The Nursing Home Administrator and Don are responsible to maintain and follow this plan of correction.	
F 881 SS=E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on staff interviews and policy review, the facility failed to implement an antibiotic stewardship program to monitor residents' antibiotic use. Findings include: A review of the infection control program on 5/17/18 at 3:00pm revealed the antibiotic stewardship program is included in the infection control program. The antibiotic stewardship program stated the facility will provide education of staff, residents and families, reduce the overall number of antibiotics, improve the specificity of antibiotic use, reduce the duration and frequency, reduce the incidence of infection through	F 881	f881 Antibiotic stewardship program 1.Process that lead to the deficiency. The antibiotic stewardship has not been updated to include how antibiotic use in residents are monitored. The facility did not have a recent record of antibiotic use in residents. 2.corrections for specific deficiencies sited The Director of nursing and Interdisciplinary team will implement and oversee the antibiotic stewardship program. The Director of nursing will educate the staff, and will also provide	6/5/18

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F 881	Continued From page 32 appropriate care measures, and reduce the incidence of catheter use. An interview was conducted with the DON (director of nursing) on 5/17/18 at 4:30pm. The DON reported she is responsible for the facility's infection control program. She revealed the antibiotic stewardship program in the infection control policy. The DON reported the antibiotic stewardship has not been updated to include how antibiotic use in residents are monitored. The DON reported she did not have a record of antibiotic use in residents. An interview was conducted with the corporate nurse consultant on 5/17/18 at 5:20pm. The consultant reported that the corporate office recognizes the facility needs to reevaluate the antibiotic stewardship program. She reported that the corporate office will be working with the staff at the facility to update the antibiotic stewardship to include updating the physicians of the formularies, having daily antibiotic discussions at the morning meeting, and implement an antibiotic monitoring system to prevent unnecessary antibiotic use. An interview was conducted with the administrator on 5/17/18 at 6:00pm. The administrator reported that it her expectation that the facility monitors all antibiotic use.	F 881	resident and family education. Pharmacy will be working with the staff and providers at the facility to update and maintain the antibiotic stewardship to include updating the physicians of the formularies, having daily antibiotic discussions at the morning meeting, and implement an antibiotic monitoring system to prevent unnecessary antibiotic use. reduce the overall number of antibiotics, improve the specificity of antibiotic use, reduce the duration and frequency, reduce the incidence of infection through appropriate care measures, and reduce the incidence of catheter use. 3.the monitoring processes and systemic changes to ensure plan of correction is effective. The Director of nursing provided education for the staff, and also provided resident and family education for all residents receiving antibiotics. The Pharmacy will provide antibiotic usage reports weekly and monthly to aid in the tracking and trending of antibiotic usage. The pharmacy and director of nursing provided education at the facility for the nursing staff, and provided tools to maintain and continue updates for the antibiotic stewardship program,also to include updating the physicians of the formularies, having daily antibiotic discussions at the morning meeting, and implement an antibiotic monitoring system to prevent unnecessary antibiotic use. The goal is to reduce the overall number of antibiotics, improve the specificity of antibiotic use, reduce the duration and	

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	345149	A. BUILDING _____ B. WING _____	C 05/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WINSTON SALEM	4911 BRIAN CENTER LANE WINSTON-SALEM, NC 27106

(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 881	Continued From page 33	F 881	frequency, reduce the incidence of infection through appropriate care measures, and reduce the incidence of catheter use. 4.The Administrator and the Director of nursing along with Interdisciplinary team will review each residents chart that has orders for antibiotic usage to ensure compliance with antibiotic stewardship program and guidelines that includes antibiotic use protocols, and complete all systems to monitor antibiotic use. weekly x 4 weeks, then monthly x 3 months to maintain affective antibiotic stewardship program, making any corrections as necessary. The results of these audits, will be monitored to ensure on going compliance, data collection to be analyzed and reviewed at monthly Quality Assessment and Assurance Committee (QAA)meeting x 3 months with subsequent POC as needed. 5. The Nursing Home Administrator and Don are responsible to maintain and follow this plan of correction.	