

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

PRINTED: 08/06/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345196</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/07/2018</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MOUNTAIN VISTA HEALTH PARK</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>106 MOUNTAIN VISTA HEALTH PARK ROAD DENTON, NC 27239</b>
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F 582 SS=C	<p>Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v)</p> <p>§483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.</p> <p>§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any</p>	F 582		7/5/18
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE <b>06/29/2018</b>
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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 582	<p>Continued From page 1</p> <p>deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.</p> <p>(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.</p> <p>(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interviews, the facility failed to provide the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) Form CMS-10055 to the facility residents prior to discharge from Medicare Part A Services for 2 of 3 residents (# 6 and # 107) reviewed.</p> <p>Findings included:</p> <p>A. Resident # 6 was admitted to the facility on 3/3/2015 with diagnoses that included hypertension, osteoarthritis and depression. Review of records revealed Resident # 6 Medicare Part A Services began on 2/2/2018 and terminated on 3/12/2018. Resident # 6 was discharged from Medicare Covered Part A stay with benefit days remaining. The SNFABN Form CMS 10055 was not provided to Resident # 6 by the facility.</p> <p>B. Resident # 107 was admitted to the facility on 2/12/2018 with general weakness, hypertension and dementia. Record review revealed Resident # 107 Medicare Part A Services began on</p>	F 582	<p>Mountain Vista Health Park (Provider) submits this Plan of Correction (PoC) in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this PoC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the Centers for Medicare and Medicaid Services (CMS), the State of North Carolina or any other entity; or (2) serve, in any way, to facilitate or promote action by any third party against the</p>		

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F 582	<p>Continued From page 2</p> <p>2/12/2018 and terminated on 3/10/2018. The SNFABN Form CMS 10055 was not provided to Resident # 107 representative by the facility.</p> <p>An interview with the business officer manager on 6/7/2018 at 10:45 AM revealed she did not issue the SNFABN to Resident # 6 and Resident # 107. She further revealed she did not know that the SNFABN Form CMS 10055 was required if the resident was issued a Notification of Medicare Non-Coverage (NOMNC) Form CMS 10123. The business office manager revealed that she has never issued the SNFABN to residents.</p> <p>An interview with the administrator on 6/7/2018 at 11:05 AM revealed she expected the business office manager to issue the SNFABN Form CMS 10055 to residents who received Medicare Part A Services prior to discharge. The administrator acknowledged that the facility had failed to provide the form to the facility residents.</p>	F 582	<p>Provider. Any changes to Providers policies or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis.</p> <p>F 582</p> <p>The provider strives to ensure that each Medicaid/Medicare Coverage/Liability eligible resident is provided, in writing, at the time of admission to the facility and when the resident becomes eligible or changes eligibility for items or services that are included in the nursing facility services under the Medicare and/or State plan and for which the resident may not be charged; and those items and services that the facility offers and for which the resident may be charged, and the amount of the charges for those services; and inform each eligible resident when changes are made to the items and services specified in 483.10(g)(17)(i)(A) and (B). The facility has policies and procedures designed to maintain these goals. Workshops, CMS websites, routine training, meetings, and various quality assurance measures are examples of the many components utilized.</p> <p>Action Plan-</p> <p>The omitted Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN) Form CMS-10055 was supplied to Resident #6</p>		

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F 582	Continued From page 3	F 582	<p>on 6/26/18.</p> <p>Per the initial admission discharge plan Resident #107 discharged home on 3/14/18 following a Medicare-A and private-pay stay. The SNFABN information was verbally communicated with resident's representative prior to discharge from Medicare-A stay. Although already discharged home a SNFABN Form CMS-10055 (2018) was mailed to the resident's representative on 6/26/2018. The signed form was returned to the facility.</p> <p>Procedure-</p> <p>Root-cause analysis was conducted and it was determined further education regarding when the SNFABN Form CMS-10055 was to be issued was needed. The Business Office Manager and Administrator reviewed the CMS guidelines and table related to the guidelines for providing notification (SNFABN Form CMS-10055) prior to discharge from Medicare Part-A services and implemented those guidelines.</p> <p>The issuance of SNFABN Form CMS-10055 will also be included in weekly Medicare meetings to assure timeliness and compliance.</p> <p>Monitoring-</p> <p>The Administrator will audit Medicare Part-A discharged residents weekly, if applicable, for 4 weeks and monthly for 2</p>		

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F 582	Continued From page 4	F 582	<p>months to ensure residents were provided notification with the SNFABN Form CMS-10055 prior to discharge from Medicare Part-A Services. Results of these audits will be submitted to the Quality Assurance Performance Improvement (QAPI) Committee monthly for 3 months. The Committee will re-evaluate the need for further monitoring after 3 months.</p> <p>Continued monitoring will also occur in the month-end Medicare Triple Check process where all residents on Medicare Part A and plans for discharge from Part A services are discussed to assure all documentation requirements are met.</p> <p>Person Responsible for Implementing Plan-</p> <p>The Administrator will be responsible for implementing, monitoring and follow up where necessary.</p>		
F 584 SS=B	<p>Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)</p> <p>§483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can</p>	F 584		7/5/18	

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F 584	<p>Continued From page 5</p> <p>receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.</p> <p>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.</p> <p>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;</p> <p>§483.10(i)(3) Clean bed and bath linens that are in good condition;</p> <p>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);</p> <p>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;</p> <p>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and</p> <p>§483.10(i)(7) For the maintenance of comfortable sound levels.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to provide a clean and comfortable interior environment for 4 of 5 rooms (Rooms # 48, 52, 55 and 61) and 1 of 2 hallways (Spring Hall) reviewed.</p> <p>Findings included:</p> <p>1. An observation in Room # 61 on 6/4/2018 at 10:20 am revealed:</p>	F 584	<p>F584</p> <p>The provider strives to ensure that the building, along with all structural, fire safety, electrical, mechanical and plumbing is maintained in a safe, clean, comfortable, homelike manner. The facility has policies and procedures designed to maintain these goals. Maintenance work repair requisitions, routine maintenance checks, safety</p>		

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F 584	<p>Continued From page 6</p> <p>a. Wallpaper to the left of the window was torn off in an approximate 3 feet by 3 feet square with sheetrock exposed.</p> <p>b. The filter to the package terminal air conditioner (PTAC) contained a moderately thick layer of dust, lint and debris.</p> <p>c. Loose and peeling joint tape on the ceiling above the doorway.</p> <p>d. A follow up observation in Room # 61 on 6/5/2018 at 4:30 pm revealed the filter contained a moderately thick layer of dust, lint and debris.</p> <p>Review of the facilities maintenance room audits dated February 2018, the only audit log on file, did not reveal any concerns to the areas observed in Rooms # 48, 52, 55 and 61.</p> <p>Review of the facilities housekeeping log revealed that the vents and PTAC filters in Rooms # 48, 52, 55 and 61 were cleaned on 4/15/2018 and 5/3/2018.</p> <p>During an interview with the Maintenance Director and Administrator on 6/6/2018 at 8:59 am both parties observed the wallpaper to the left of the window that was torn off in an approximate 3 feet by 3 feet square with sheetrock exposed in Room # 61. The Maintenance Director revealed that he was not aware of the walls condition. The Administrator revealed that she was aware of the walls condition and it had been in that state for an extended time.</p> <p>2. An observation in Room # 55 on 6/4/2018 at 2:31 pm revealed:</p> <p>a. Wallpaper torn in a scaling pattern to the left of the window.</p> <p>b. Brown water stains to the ceiling in the corner next to the window.</p>	F 584	<p>committee audits and meetings, and various quality assurance measures are examples of the many components utilized.</p> <p>Action Plan-</p> <p>An outside contractor had already been contacted and scheduled to complete ceiling, sheetrock and wallpaper repairs prior to the survey. Contractor came during survey and confirmed being contacted and scheduled.</p> <p>Room #61-</p> <p>(a) The wallpaper was repaired by the outside contractor on 6/28/18.</p> <p>(b) The package terminal air conditioner (PTAC) filter was cleaned by housekeeping on 6/21/18.</p> <p>(c) The joint tape to the ceiling was repaired by the outside contractor on 6/28/18.</p> <p>Room # 55-</p> <p>(a) The wallpaper was repaired by the Maintenance Director on 6/26/18.</p> <p>(b) The ceiling stain from an Heating, Ventilation, and Air Conditioning(HVAC) drain line leak was painted by the Maintenance Director on 6/26/2018.</p> <p>Room # 52-</p> <p>(a) The privacy curtain was replaced and washed by housekeeping on 6/7/2018.</p> <p>(b) Upon inspection, the corner protector was not cracked or broken. It was separated from the top cap. On 6/8/18 the Maintenance Director slid cap back in</p>		

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F 584	Continued From page 7  An interview with Aide #1 on 6/5/2018 at 4:17 pm revealed that she was frequently assigned to Rooms # 48, 52, 55 and 61. She revealed that all staff could submit maintenance requisitions for work orders. Aide # 1 reported that a copy of the maintenance requisition went to the administrator and the other copy was placed in a mailbox centrally located for the maintenance director. She further revealed that she was not sure who cleaned the vents and filters but housekeeping washed the privacy curtains. Aide # 1 was assigned to Room # 55 and was aware of the torn wallpaper and brown water stains on the ceiling but had not completed any work orders to maintenance.  3. An observation in Room # 52 on 6/6/2018 at 10:48 am revealed: a. Dark brown dried substance on the privacy curtain of the bed near the door. b. The plastic corner protector at the bathroom entrance was cracked and broken at the top.  4. An observation in Room # 48 on 6/6/2018 at 10:50 am revealed: a. The plastic corner protector at the bathroom entrance was cracked and broken at the top. b. Peeled and hanging wallpaper near the right side of the overhead light by the bed next to the window.  An interview with Housekeeper # 1 on 6/6/2018 at 10:43 am revealed she regularly was assigned to Rooms # 48, 52, 55 and 61. She further revealed that housekeeping staff reported work orders to maintenance, filter cleaning was done by	F 584	place and refastened protector at bottom track to prevent future slippage.  Room # 48- (a) Upon inspection, the corner protector was not cracked or broken. It was separated from the top cap. On 6/8/18 the Maintenance Director slid cap back in place and refastened protector at bottom track to prevent future slippage. (b) The wall paper was repaired by the Maintenance Director on 6/26/2018.  Corridor Ceiling- (a) The ceiling on Spring Hall near the nurse's station was repaired and painted by the outside contractor on 6/28/2018. (b) The loose joint tape was corrected by the outside contractor on 6/28/2018.  An audit was completed by the Housekeeping Director and Maintenance Director on 6/25/18 to ensure no other facility repairs were needed including, but not limited to, walls, wallpaper, ceilings, and corner protectors.  An audit was completed by the Housekeeping Director on 6/25/2018 to ensure the package terminal air conditioner (PTAC) filters were clean and free from debris and privacy curtains were clean. Any filters that needed cleaning were cleaned.  Procedure  The Administrator, Maintenance Director and Housekeeping Director reviewed the		



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F 584	<p>Continued From page 8</p> <p>maintenance and the housekeeping supervisor was responsible for cleaning the privacy curtains. Housekeeping #1 had not completed any work orders to maintenance for Rooms # 48, 52, 55 or 61.</p> <p>An interview with the Housekeeping Supervisor on 6/6/2018 at 12:36 pm revealed that housekeeping staff cleaned the PTAC filters monthly and mattresses and privacy curtains biannually or when residents depart or are removed from isolation. The Housekeeping Supervisor further revealed that there was no formal method of checking or auditing the condition of the rooms. She reported that she relied on the facility staff to notify when housekeeping is needed. The Housekeeping Supervisor provided an informal log of handwritten notes as the cleaning log.</p> <p>5. An observation of the ceiling on Spring Hall near the nurse's station on 6/5/2018 revealed:</p> <ol style="list-style-type: none"> <li>An approximately 4 feet by 3 feet oval area of brown water stained ceiling with three 6-inch pieces of dangling sheetrock.</li> <li>Loose and peeling joint tape.</li> </ol> <p>During an interview with the Maintenance Director and Administrator on 6/6/2018 at 8:59 am both parties observed the approximately 4 feet by 3 feet oval area of brown water stained ceiling with three 6-inch pieces of dangling sheetrock on the Spring Hall near the nurse's station. The Administrator revealed that she was aware of condition of the ceiling but there were no current work orders to repair the area.</p> <p>An interview with the Maintenance Director and Administrator on 6/6/2018 at 8:59 am revealed</p>	F 584	<p>current processes involving maintenance repairs and cleaning and determined the issues identified with the interior of 4 resident rooms was a human oversight related to staffing changes within the Maintenance Department for a short period of time. Based on the analysis of findings the following new processes were implemented by the Administrator, Maintenance Director and Housekeeping Director on 7/20/18.</p> <ol style="list-style-type: none"> <li>1) A log will be maintained by the Administrator recording all work contracted with outside contractors.</li> <li>2) The Maintenance Director will conduct maintenance rounds monthly within the facility to observe any physical environmental areas such as torn wallpaper, peeling paint and water stains in need of repair. The Housekeeping Director or Administrator will be assigned this responsibility in the absence of the Maintenance Director.</li> <li>3) A checklist was developed by the Administrator to alert/guide the Maintenance Director to pertinent areas of observation during the monthly maintenance rounds.</li> <li>4) The Administrator and Housekeeping Director reviewed the current cleaning schedule to determine if the schedule was adequate or needed revision. The cleaning of privacy curtains will now be included in the quarterly deep cleaning schedule.</li> </ol>		

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F 584	<p>Continued From page 9</p> <p>the Administrator assumed responsibility of maintaining the facility's maintenance system. The Administrator revealed that was no formal maintenance process, as the staff submitted the work orders she prioritized which order needed to completed first. The Administrator further revealed that she kept all records of the maintenance work order requisitions.</p> <p>An interview with the Administrator on 6/7/2018 at 11:05 am revealed that she expected all the residents in the facility to have a clean and comfortable environment free from disrepair. She further revealed that she expected all staff to submit work orders to the maintenance box for conditions that needed to be repaired.</p>	F 584	<p>5) The Housekeeping staff was provided in-service training beginning on 6/22/18. The in-service emphasized the need to promptly fill out Repair Requisition forms if they notice areas in need of repair while cleaning.</p> <p>6) Refresher training will be conducted beginning 6/22/18 with all staff on how to submit repair requisitions for maintenance repairs and communication tools regarding notifying housekeeping of areas that need attention/cleaning. Emphasis placed on the responsibility of staff to continually observe for environmental cleanliness and furnishings that may need to be repaired.</p> <p>Monitoring</p> <p>Auditing will be conducted by the Administrator or Director of Nursing as follows: a) Inspections will be made on eight resident rooms to determine if the area is safe/clean and not in need of any repair. b) Review the laundry and housekeeping schedules to assure rooms have been cleaned per schedule. c) Review repair requisitions to assure a repair has been completed or the task has been scheduled to be completed timely. This auditing will occur weekly for 4 weeks and then monthly for two months.</p> <p>The results of these audits will be submitted to the Quality Assurance Performance Improvement (QAPI) committee monthly for three months. The</p>		

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F 584	Continued From page 10	F 584	Committee will review the results and re-evaluate the need for further monitoring after three months.  Person Responsible for Implementing Plan  The Administrator, Maintenance Director, Housekeeping Director will be responsible for implementing, monitoring and follow up.		
F 585 SS=B	Grievances CFR(s): 483.10(j)(1)-(4)  §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.  §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.  §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.  §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights	F 585		7/5/18	

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F 585	Continued From page 11 contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect,	F 585			

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F 585	<p>Continued From page 12</p> <p>abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;</p> <p>(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;</p> <p>(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and</p> <p>(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, resident interview, and staff interviews the facility failed to record a grievance and failed to provide a written grievance summary for 2 of 2 residents reviewed for grievances (Resident #20 and Resident #27).</p> <p>Findings include:</p> <p>1. Resident #20 was most recently readmitted on 3/6/18 and was originally admitted on 11/14/14.</p>	F 585	<p>F 585</p> <p>The provider strives to ensure that the resident and their representative receive information on how to file a grievance or complaint and that resident grievance(s) voiced to the facility or other agencies are heard and if possible resolved in a timely manner. The facility has policies and procedures designed to maintain these goals. Admission notices, care plan</p>		

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F 585	<p>Continued From page 13</p> <p>Resident #20's cumulative diagnoses which included: Dysphagia, Parkinson's disease, and heart failure.</p> <p>Review of Resident #20's most recent Minimum Data Set (MDS) revealed a quarterly assessment with an Assessment Reference Date (ARD) of 4/12/18. The resident was coded as having been cognitively intact. The resident was coded as having had no hallucinations or delusions and did not display any abnormal behavior.</p> <p>An interview was conducted with Resident #20 on 6/4/18 at 3:09 PM. Resident #20 stated he had 2 shirts which were missing, University of South Carolina (USC) shirts, one black and one garnet colored. The resident stated he had reported it to a staff person at the facility and he had been told by a facility staff person the shirt had been looked for but shirt could not be located.</p> <p>Review of the facility grievances since 3/1/18 revealed no recorded grievances in regards to Resident #20 alleging he was missing any items.</p> <p>An interview was conducted on 6/6/18 at 4:41 PM with the Activities Director (AD) and Resident #20. The resident stated he was missing three USC shirts, one was garnet and the other two were black. The AD looked into the resident's closet and found one garnet USC shirt. The resident stated the shirt was not the shirt which was missing. The AD continued to look for the alleged missing shirts and she was unable to locate them. The AD informed the resident she was going to look for his alleged missing shirts.</p> <p>An interview was conducted on 6/7/18 at 11:59 PM with the AD. The AD stated she had ordered</p>	F 585	<p>meetings, resident council meetings, family meetings, notice postings, social work visits, other points of contact and various quality assurance measures are examples of the many components utilized.</p> <p>Action Plan-</p> <p>A written grievance form was completed by Housekeeping/Laundry Director on 6/7/2018 regarding Resident #20 report of 3 missing shirts. Investigation conducted. One shirt found in closet on 6/6/18. Responsible party indicated unaware of ownership of 3 sports shirts. Investigation was unable to confirm resident actually missing 2 others. Resident insisted that missing items be replaced and facility purchased three shirts on 6/25/2018. Resident acknowledged on grievance form the issue was resolved.</p> <p>A grievance form was completed by the Director of Nursing on 6/7/2018 regarding Resident #27's report of missing money. Investigation conducted. Upon investigation resident #27's representative stated the \$5 in resident #27's wallet was the only money she had and none was missing. Resident #27's representative signed grievance form acknowledging conclusion.</p> <p>Audits conducted by Administrator (Grievance Officer) beginning 6/8/18 to ensure written grievance documentation and investigations are completed per guidelines and policy and procedures.</p> <p>Procedure</p>		

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F 585	<p>Continued From page 14</p> <p>three shirts for the Resident #20 to replace the alleged missing shirts. The AD stated she told the Administrator about the alleged missing shirts.</p> <p>An interview was conducted on 6/7/18 at 12:18 PM with the AD. The AD stated she had completed a Missing/Damaged Item Form for the alleged missing shirts of Resident #20. The AD stated she had not completed a grievance/complaint form for the resident's alleged missing shirts.</p> <p>An interview conducted on 6/7/18 at approximately 12:30 PM was conducted with the Housekeeping Director (HD). The HD stated she had not completed a grievance form for missing clothing articles. The HD stated the process usually was to write a note and pin it on the bulletin board if a resident informed her of missing clothing items.</p> <p>An interview was conducted with the Administrator on 6/7/18 at 1:52 PM. The Administrator stated the facility had not been completing grievance forms for missing items such as clothing. The Administrator stated grievance forms were available at the nurses' station and it was the responsibility of the nurses give out or fill out a grievance form. The Administrator stated it was her expectation to complete a grievance form if an item was established as missing.</p> <p>2. Resident #27 was admitted to the facility on 4/13/18. Resident #20's admission diagnoses included: Diabetes, dementia, and anxiety.</p> <p>Review of Resident #27's most recent Minimum Data Set (MDS) revealed a comprehensive</p>	F 585	<p>Administrator and Director of Nursing began staff refresher training on 6/22/18 regarding facility grievance process and policy and procedures including but not limited to completing written grievance documentation. Training on the facility grievance process will be included in annual mandatory employee in-service on resident rights and this in-service will be provided to all new employees as part of orientation.</p> <p>Monitoring- The Administrator will conduct audits weekly for 4 weeks and monthly for 2 months to ensure written grievance documentation continues to be completed per policy and procedures. The results of these audits will be submitted to the Quality Assurance Performance Improvement (QAPI) Committee monthly for 3 months. The Committee will re-evaluate the need for further monitoring after 3 months.</p> <p>Person Responsible for Implementing Plan The Administrator will be responsible for implementing, monitoring and follow up where necessary.</p>		

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F 585	<p>Continued From page 15</p> <p>admission assessment with an Assessment Reference Date (ARD) of 4/20/18. The resident was coded as having had moderately impaired cognition. The resident was coded as having had no hallucinations or delusions and had not displayed any abnormal behavior.</p> <p>An interview was conducted with Resident #27 on 6/4/18 at 10:38 AM. Resident #27 stated she had had some money come up missing.</p> <p>Review of the facility grievances since 10/1/17 revealed no recorded grievances in regards to Resident #27 alleging she was missing any items.</p> <p>An interview was conducted with the AD and Resident #27 on 6/7/18 at 12:05 PM. The resident informed the AD she had some missing money. The AD stated to the resident she would discuss the missing money with the resident's nurse. The AD looked in the resident's night stand and discovered a wallet with a \$5 bill in it. The resident stated her husband had recently placed the \$5 bill in the wallet to replace the money which was missing.</p> <p>An interview was conducted with the AD on 6/7/18 at 12:06 PM with the AD. The AD stated she would follow up with the resident's nurse because some residents had made allegations of missing money but the residents actually had not had money. The AD further explained residents were sometimes confused and had alleged to have had missing money but had not actually had money or money which was missing. The AD also stated she was going to inform the Administrator. The AD added the resident's husband was supposed to be visiting the facility in the afternoon and she would discuss the alleged</p>	F 585			



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F 585	<p>Continued From page 16</p> <p>missing money with him when he arrived. The AD stated she would not fill out a grievance form for the alleged missing money.</p> <p>An interview was conducted with Nurse #1 on 6/7/18 at 12:08 PM. The nurse stated she would tell the Social Worker (SW) about the missing money Resident #27 had alleged was missing. The nurse stated if the SW was not at the facility then she would look for the money herself. The nurse added she would tell oncoming nurses about the alleged missing money in the shift report. The nurse stated she would not fill out a grievance form the alleged missing money.</p> <p>An interview was conducted with the Administrator on 6/7/18 at 1:52 PM. The Administrator stated the facility had not been completing grievance forms for missing items. The Administrator stated a grievance form had not been completed for Resident #27's alleged missing money because the facility staff was in the midst of investigating if the alleged money was really missing. The Administrator stated grievance forms were available at the nurses' station and it was the responsibility of the nurses give out or fill out a grievance form. The Administrator stated it was her expectation to complete a grievance form if an item was established as missing.</p>	F 585			