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THE GRAYBRIER NURS & RETIREMENT CT	116 LANE DRIVE TRINITY, NC 27370

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F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on review of the resident council meeting	F 565	The Director of Recreation Services, who	7/31/18

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

Electronically Signed | 07/27/2018

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F 565	Continued From page 1 minutes, record review, and interviews with residents and staff, the facility failed to resolve grievances that were reported in the resident council meetings for 3 of 3 consecutive months. The findings included: A Resident Council meeting was conducted on 7/10/18 at 1:30 PM with 11 active members of the resident council. This meeting revealed an issue with the resolution of concerns reported during the Resident Council meetings. Multiple group members reported a shared concern that had been discussed in 3 consecutive Resident Council meetings that had not been resolved/improved by facility staff. This concern was regarding soiled briefs and/or linens being left in open trash cans or on the floor in the resident bathrooms. The residents indicated this continued to be a concern. The Resident Council meeting minutes from April 2018, May 2018, and June 2018 were reviewed. The Resident Council minutes dated 4/26/18 indicated the residents voiced concerns of soiled briefs being left in open trash cans in the resident bathrooms. The Resident Council follow-up notes for the 4/26/18 meeting indicated staff were reminded to remove soiled linens from rooms after care and for staff who were assigned residents who were independent with toileting to frequently check their trash cans for disposal of soiled items. This form was signed by the Director of Nursing (DON) on 5/1/18. The Resident Council minutes dated 5/31/18	F 565	was responsible for routing grievances as initiated in the Resident Council failed to adequately notify departments of grievances and/or the on-going nature of specific grievances in the resident council meetings. Due to the above mentioned lack of communication, grievance follow up was not addressed timely by other departments. The Director of Recreation Services responsible for ensuring grievances initiated in the Resident Council meetings are addressed timely is no longer employed by the facility. The facility hired a new Director of Recreation Services. The Director of Recreation Services, the Nursing Home Administrator, and a corporate team member reviewed Resident Council grievances for the past quarter. Unresolved grievances for the past quarter (April, May, and June) were addressed with residents at the July 26, 2018 Resident Council meeting to ensure corrective action has been obtained. The facility implemented a new process to monitor follow up with concerns; concerns will be given to each department in a narrative format within 2 business days of the council meeting. The Director of Recreation Services will route to each department representative and follow-up will be provided with the specific resident (or Resident Council members) within one week of the Resident Council meeting. If grievances are not able to be resolved within one week, on-going follow up will be offered as needed; follow up should be concluded no later than the next	

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F 565	Continued From page 2 indicated soiled briefs continued to be left in open trash cans. Staff were reportedly reminded to take soiled linens out of the resident rooms. The Resident Council follow-up notes for the 5/31/18 meeting indicated staff continued to be reminded to remove soiled linens and briefs from rooms as quickly as possible. This form was signed by the DON on 6/4/18. The Resident Council minutes dated 6/28/18 indicated the staff continued to be reminded to make sure soiled linens were removed from the resident rooms as soon as care was completed. The Resident Council follow-up notes for the 6/28/18 meeting indicated staff continued to be encouraged to remove soiled linens right after they completed their care. This form was signed by the DON on 7/4/18. An interview was conducted with the DON on 7/11/18 at 10:00 AM. The Resident Council minutes from April through June 2018 as well as the corresponding Resident Council follow-up notes were reviewed with the DON. The repeat concerns regarding soiled linens and/or briefs being left in resident bathrooms was reviewed with the DON. She revealed she was aware this was a repeat concern for 3 consecutive months. She stated that staff continued to be educated on removing soiled linens and/or briefs promptly after care and frequently checking the bathrooms of residents who were independent for toileting to remove any soiled items. She explained that after hearing that this was a continued concern and that it had not been resolved she was now thinking the root cause may be the second shift Nursing Assistants (NAs) as there were several	F 565	scheduled Resident Council meeting. The new Director of Recreation Services will monitor grievances initiated in Resident Council meeting for six months using the Resident Council meeting minutes. Grievances that cannot be resolved within one week will be routed to the Administrator and a corporate representative, in an attempt to expedite the concern resolution. If a grievance cannot be resolved timely or resolved at all, this will be communicated with the Council and recorded in the minutes. The Director of Recreation Services will report any concern follow up taking more than one week to the QA committee for the duration of the monitoring. The next executive QA meeting is scheduled July 31, 2018. The Director of Recreation Services will be responsible for implementing this portion of the plan of correction. The facility alleges compliance with all aspects of this portion of the plan of correction as of 7/31/18.	

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F 565	Continued From page 3 PRN (as needed) employees who filled in on second shift due to a lack of consistent second shift NAs. The DON stated she expected that this repeat concern would have been resolved and/or improved over the 3-month time period. She indicated it was on ongoing process to improve on this concern.	F 565		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications.	F 636		7/31/18

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F 636	Continued From page 4 (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to comprehensively assess a resident on the Minimum Data Set (MDS) assessment in the areas of cognition, mood, and pain for 1 of 1 residents reviewed for hospice (Resident #9). The findings included:	F 636	The Minimum Data Set (MDS) assessment errors noted for resident #9, specific to coding for sections C and D were miscoded due to human error during data entry. Each section was coded “0” which should have been coded “1” and then follow the next corresponding steps. For section J, the current MDS Nurse was	

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Resident #9 was most recently readmitted to the facility on 3/12/18 with diagnoses that included heart failure, atrial fibrillation, hypertension, and dementia.

The significant change MDS assessment dated 3/22/18 indicated her cognition was moderately impaired with a score of 11 out of 15 on the Brief Interview for Mental Status (BIMS).

A Monthly Summary nursing note dated 6/6/18 indicated Resident #9 was alert, verbal, and oriented to self.

A Social Service Assessment note, completed by Social Worker (SW) #1, dated 6/22/18 indicated Resident #9 was alert. She was noted as verbal at times with periods of forgetfulness and confusion. Resident #9 was assessed with clear speech, the ability to be understood by others and to understand others.

A Resident Summary nursing note dated 6/22/18 indicated Resident #9 was able to verbalize and communicate pain.

The quarterly Minimum Data Set (MDS) assessment dated 6/22/18 indicated Resident #9 had clear speech, was able to make herself understood, and was able to understand others. Section C, the Cognitive Patterns section, was not comprehensively assessed for Resident #9. Question C0100 was coded to indicate Resident #9 was rarely/never understood and the BIMS (questions C0200 through C0500) was not conducted. Section D, the Mood section, was not comprehensively assessed for Resident #9. Question D0100 was coded to indicate Resident #9 was rarely/never understood and the resident previously trained to select “0” to go on to the staff interview portion; the surveyor explained this should have been coded “1” (J0200), then “9” (J0300). Both coding methods lead to the staff interview (J0800), which was the end goal as the resident was unable to answer.

The MDS assessment for resident #9 was corrected for coding of sections C, D, and J. The Social Work Assistant was responsible for re-coding sections C and D on resident #9 by 7/31/2018. The MDS Nurse corrected section J of the MDS assessment for resident #9 by 7/31/2018. A corporate team member with Social Services expertise provided in-services to the Director of Social Work and Social Worker on 7/31/2018 to ensure accurate coding of MDS assessments. The MDS Nurse was able to review the Resident Assessment Instrument (RAI) manual and agrees that the surveyor recommended method was the correct method as opposed to how she was trained; she has begun using this method for coding similar MDS assessments. A new MDS Coordinator was hired and is expected to begin in August 2018. She will assist the MDS Nurse with training as needed. The facility also plans to have the MDS Nurse to attend off site training as this becomes available.

The facility created a new Quality Assurance (QA) team, The 2018 Annual Survey Plan of Correction QA Team, to implement the plan of correction. The QA team consists of the following members:

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mood interview (questions D0200 through D0300) was not conducted. Section J, the Health Conditions section, was not comprehensively assessed for Resident #9. Question J0200 was coded to indicate Resident #9 was rarely/never understood and the resident pain assessment interview (questions J0300 through J0600) was not conducted.

An interview was conducted with SW #1 on 6/8/17 at 9:25 AM. SW #1 indicated she completed Section C and D on Resident #9 ' s quarterly MDS assessment dated 6/22/18. Section C and D of the 6/22/18 MDS for Resident #9 was reviewed with SW #1. She reported she attempted the resident interviews for Sections C and D with Resident #9, but she was unable to answer the questions appropriately. She indicated this was the reason she had coded Resident #9 as rarely/never understood. She revealed that Resident #9 was not rarely/never understood even though she was not able to answer the questions appropriately during the resident interviews for the 6/22/18 MDS. SW #1 stated she was unaware of the coding instructions specified in the Resident Assessment Instrument (RAI) manual for the completion of the resident interviews in Sections C and D.

An interview was conducted with the MDS Nurse on 7/12/18 at 11:40 AM. The MDS Nurse indicated she completed Section J on Resident #9 ' s quarterly MDS assessment dated 6/22/18. Section J of the 6/22/18 MDS for Resident #9 was reviewed with the MDS Nurse. She reported she attempted the resident interview for Section J with Resident #9, but she was unable to answer the questions appropriately. She indicated this was the reason she had coded Resident #9 as

the Administrator, Director of Nurses, Quality Assurance Nurse, MDS Nurse, Therapy Manager, Unit Coordinator(s), a Social Worker, a dietary representative (Certified Dietary Manager or Dietary Manager in training), and a corporate team member at select meetings. The updated process/procedure for verifying the accuracy of the MDS assessment sections was in-serviced to the MDS Nurse (and other administrative staff members) by the Administrator on 7/27/2018. A new QA tool the “MDS Assessment Accuracy Tracking Log” was created to ensure MDS assessments are checked and verified as accurate. The two MDS nurses of the facility will keep their own logs. Prior to transmission, the MDS nurses will review assessments completed by one another. Assessments will be audited on the above mentioned log for at least one assessment cycle on each resident currently residing in the building. (One assessment cycle = short term residents will have all remaining Prospective Payment System (PPS) or Omnibus Budget Reconciliation Act (OBRA) required assessments audited; long-term residents will have his/her next scheduled quarterly, significant change, or annual assessment audited). The 2018 Annual Survey Plan of Correction QA team will meet weekly and will use the MDS Assessment Accuracy Tracking Log to guide their monitoring efforts. The 2018 Annual Survey Plan of Correction QA team will meet weekly for a minimum of the next 6 months and will meet monthly thereafter to ensure the plan of

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F 636	Continued From page 7 rarely/never understood. She revealed that Resident #9 was not rarely/never understood even though she was not able to answer the questions appropriately during the resident interview for the 6/22/18 MDS. The MDS Nurse stated she was unaware of the coding instructions specified in the RAI manual for the completion of the resident pain assessment interview in Section J. An interview was conducted with the Director of Nursing (DON) on 7/12/18 at 12:25 PM. She indicated her expectation was for all residents to be comprehensively assessed in all areas of the MDS.	F 636	correction remains in compliance with regulations. During the QA meetings, the log of completed/audited MDS assessments will be reviewed by the team members to ensure auditing and accuracy efforts remain in place are effective as well. The MDS Coordinator will be responsible for bringing the log (including any supporting documentation) to the QA meetings. The MDS Coordinator will also be responsible for reporting the QA team's monitoring efforts at the Executive Quarterly QA meetings. The next scheduled Executive Quarterly QA meeting is scheduled for 7/31/2018. The MDS Nurse for the facility will be responsible for implementing this portion of the plan of correction. The facility alleges compliance with all aspects of this portion of the plan of correction as of 7/31/2018.	
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	F 637		7/31/18

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F 637	Continued From page 8 care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility failed to complete a significant change Minimum Data Set (MDS) for a resident with multiple areas of psychological, physical and functional decline for 1 (Resident #26) of 3 residents reviewed for pressure ulcers. The findings included: Resident #26 was admitted 9/15/16 with cumulative diagnoses of major depression, Hypertension and Diabetes. Review of Resident #26's medical record indicated she was involuntary committed to a specialized facility for suicidal ideations 6/5/17 through 6/13/17. Upon discharge back to the facility, she was prescribed a new antipsychotic medication. Resident #26's weight was 162 pounds on 9/1/17. Resident #26's quarterly Minimum Data Set (MDS) dated 9/18/17 indicated she had moderate cognitive impairment and exhibited no behaviors. She was coded as ambulating in the hall with extensive assistance of one staff, extensive assistance with transfers, independent with eating, occasionally incontinent of urine and always continent of bowel, weight of 162 pounds, intact skin and taking antipsychotics. Resident #26's weight was 155 pounds on 10/2/17. Resident #26's weight on 11/2/17 was unchanged at 155 pounds.	F 637	Upon review of the deficiency, the facility found there was a knowledge deficit related to the significant change in status requirements at the time a Significant Change in Status Assessment (“SCSA”) should have been completed. Due to the timing of the missed SCSA as cited (January 2018), a new assessment could not be initiated or completed. Through experience, the Minimum Data Set (MDS) nurse is more knowledgeable of the MDS requirements related to SCSAs. SCSAs are currently being completed. New orders, weight changes, wound notes, falls, and other interdisciplinary team interaction during the daily stand up meetings and weekly Quality Indicator (QI) meetings helps MDS nurse(s) discover when a SCSA is required. The MDS nurse, Director of Nurses (DON), and Administrator have been educated by the Chief Operating Officer (COO) on 7/31/2018 of the SCSA requirements so they may also assist in discovering potential significant changes and when a SCSA may need to be initiated. The facility will continue to host daily and weekly interdisciplinary team meetings, during these meetings the MDS nurse(s) will determine if resident changes warrant a SCSA. The MDS Nurse will utilize a tool that was created to assist with monitoring SCSAs; the tool is titled “Significant	

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F 637	Continued From page 9 Resident #26 was started on physical therapy on 11/13/17 due to a functional decline in her transfers. Resident #26's quarterly MDS dated 11/27/17 indicated she cognitively intact and exhibited no behaviors. She required extensive assistance with transfers, no ambulation in the hall, independent with eating, occasionally incontinent of urine and always continent of bowel, weight of 155 pounds, intact skin and taking antipsychotics. Resident #26's weight on 12/1/17 was 145 pounds. Resident #26 developed a stage 2 pressure ulcer on 12/25/17. Resident #26's weight on 1/3/18 was 141 pounds. Resident #26's pressure ulcer was downgraded to unstageable on 1/11/18. Resident #26's quarterly MDS dated 1/27/18 indicated she cognitively intact and exhibited no behaviors. She required total assistance with transfers, no ambulation in the hall, extensive assistance with eating, frequently incontinent of urine and always continent of bowel. Her weight was 141 pounds, she was coded for one stage 2 pressure ulcer and taking antipsychotics. Resident #26's weight on 2/5/18 was 138 pounds. Resident #26's weight on 3/5/18 was 134 pounds. Resident #26's weight on 4/4/18 was 132 pounds.	F 637	Change Trigger Log." Monitoring will be utilized on residents with a decline or improvement in at least 2 areas, which would justify the need for a SCSA. The Significant Change Trigger Log will be used weekly for at least 6 months. An audit was completed by the interdisciplinary team (MDS Nurse, DON, and Administrator) to ensure no SCSA were missed for the current quarter, as of 7/xx/2018 there were no missed SCSA that could be discovered by the internal audit. The MDS Nurse for the facility will be responsible for implementing this portion of the plan of correction. The facility alleges compliance with all aspects of this portion of the plan of correction as of 7/31/2018.	

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Resident #26's annual MDS dated 4/11/18 indicated she was cognitively intact, exhibited hallucinations and her behaviors symptoms was coded as worse. She required extensive assistance with transfers, no ambulation in the hall, limited assistance with eating, always incontinent of urine and bowel. Her weight was 132 pounds, she was coded for one stage 4 pressure ulcer and taking antipsychotics.

Review of the Nutrition Care Area Assessment (CAA) dated 4/11/18 indicated Resident #26 was seen by Speech Therapy due to dysphagia. Resident #26 was noted with significant weight loss of 15% in 180 days and had an unstageable pressure ulcer to her coccyx.

Review of the Pressure Ulcer CAA dated 4/11/18 indicated Resident #26 had an unstageable pressure ulcer to her coccyx due to her immobility and incontinence.

Resident #26's weight on 5/4/18 was 133 pounds.

Resident #26's weight on 6/4/18 was 130 pounds.

Review of Resident #26's care plan last revised 6/13/18 indicated she was incontinent of bladder and bowel, care planned for pain associated with a functional decline and a stage 4 pressure ulcer, taking antipsychotic medication and at risk for further significant weight loss.

Resident #26's weight on 7/9/18 was 130 pounds.

In an interview on 7/9/18 at 2:32 PM, Resident #26 stated she had a pressure ulcer to her coccyx. She stated it caused occasional discomfort but was effectively managed by the

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facility. There was observed an alternating pressure mattress to her bed along with a trapeze to aid in self-regulated pressure relief by Resident #26.

In an interview on 7/10/18 at 7:45 AM, Resident #26 reported she had lost nearly 40 pounds in recent months and stated she did not have an appetite since her husband died over a year ago.

In an observation on 7/11/18 at 7:57 AM, Resident #26 was sitting up in bed eating breakfast. She ate 75% of her meal.

In an interview on 7/11/18 at 11:40 AM, Nursing Assistant (NA) #2 stated Resident #6 seldom wanted to get out of bed. NA #2 stated Resident #26's had a decline in status in recent months.

In an observation and interview on 7/11/18 at 12:13 PM, Resident #26 was sitting up in her wheelchair but stated she preferred to be in bed. She stated she was waiting on her sister to arrive. Resident #26 stated her sister came daily to eat lunch with her.

In an observation on 7/11/18 at 2:11 PM, Nurse #2 and Nurse #3 provided wound care. There was not observed concerns. Nurse #3 stated Resident #26 had declined quickly over the last 6 months or so. He stated Resident #26 was receiving psychological services for severe depression.

In a telephone interview on 7/11/18 at 4:50 PM, the Wound Consultant Nurse stated the pressure ulcer was unavoidable due to Resident #26's overall decline.

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F 637	Continued From page 12 In a telephone interview on 7/12/18 at 9:02 AM, the Registered Dietician stated she carefully monitored Resident #26's intake and alternated her supplements as needed. She stated the continued weight loss was likely unavoidable since Resident #26 has experienced an over-all decline. In an interview on 7/12/18 at 9:21 AM, the Nurse Practitioner stated Resident #26's pressure ulcer, functional decline and weight loss was unavoidable and that Resident #26 would be a good candidate for Hospice but it had not yet been discussed with Resident #26. In an interview on 7/12/18 at 11:35 AM, the MDS Nurse stated given the psychological, physical and functional decline in Resident #26, the annual MDS completed 4/11/18 should have been a significant change MDS to accurately reflect her condition. In an interview on 7/12/18 at 12:26 PM, the Director of Nursing stated it was her expectation that a significant change MDS would have been completed to reflect Resident #26 declining condition.	F 637		
F 640 SS=E	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment.	F 640		8/2/18

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(ii) Annual assessment updates.
(iii) Significant change in status assessments.
(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.

§483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved

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F 640	Continued From page 14 by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to electronically transmit resident's Minimum Data Set (MDS) assessments to the Centers of Medicare and Medicaid Services (CMS) system within 14 days after completion for 2 of 12 sampled residents reviewed (Residents # 162 & #35). Findings included: 1. Resident #162 was admitted to the facility on 5/18/18. Resident #162 had a 5 day/admission assessment completed on 5/31/18. On 7/12/18, review of the CMS system revealed that the 5 day/admission assessment with assessment reference date (ARD) of 5/25/18 and completion date of 5/31/18 was not transmitted to the CMS system. On 7/12/18 at 11:50 AM, the MDS Nurse was interviewed. She stated that she started as MDS Nurse in October 2017 and she was still learning. She stated that she was not responsible for transmitting the MDS assessments to the CMS system. She indicated that the previous MDS Nurse was responsible for the transmission and when she left in June 2018, the administrator took over the transmission. On 7/12/18 at 12:29 PM, the Director of Nursing (DON) was interviewed. She stated that she expected the MDS assessments transmitted as required by CMS. On 7/12/18 at 1:45 PM, the Administrator was interviewed. He stated that he was presently	F 640	The Administrator is currently responsible for transmitting MDS assessments. The Administrator and Minimum Data Set (MDS) Nurse were unaware Medicare Advantage (MA) assessments were not being transmitted, even though they were submitted to Centers for Medicare and Medicaid Services (CMS) in the submission batch file. It was determined that MA claims must be split so Omnibus Budget Reconciliation Act (OBRA) required assessments will be submitted if they are joined with a non-OBRA assessment. Only OBRA required assessments can be transmitted through the CMS system. There were two issues noted: an “admit/5day” and a “5day/Q” was not submitted. It was found that the 5 day assessment (which cannot be submitted) “blocked” the admit and quarterly assessments from being submitted. 2 of 12 assessments as cited were correctly split by the MDS Nurse and re-transmitted using the CMS system by the Administrator; assessment submission and transmission was confirmed by the Administrator on 8/2/2018. The Administrator (only staff member that currently transmits MDS assessments) completed re-training of the Electronic Medical Record (EMR) functions to ensure compliance with MDS submission standards; re-training was provided by the	

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F 640	Continued From page 15 responsible for transmitting the MDS assessments to the CMS system. The Administrator was unable to explain why the MDS assessment dated 5/31/18 for Resident #162 was not transmitted to the system. 2. Resident # 35 was originally admitted to the facility on 1/6/18 and was readmitted on 4/12/18. Resident #35 had admission MDS assessment completed on 1/13/18. On 4/8/18, she was discharged to the hospital and was readmitted on 4/12/18. Resident #35 had a 5 day/quarterly MDS assessment with ARD date of 4/19/18 and completion date of 4/23/18. On 7/12/18, review of the CMS system revealed that the 5 day/quarterly assessment with assessment reference date (ARD) of 4/19/18 and completion date of 4/23/18 was not transmitted to the CMS system. On 7/12/18 at 11:50 AM, the MDS Nurse was interviewed. She stated that she started as MDS Nurse in October 2017 and she was still learning. She stated that she was not responsible for transmitting the MDS assessments to the CMS system. She indicated that the previous MDS Nurse was responsible for the transmission and when she left in June 2018, the administrator took over the transmission. On 7/12/18 at 12:29 PM, the Director of Nursing (DON) was interviewed. She stated that she expected the MDS assessments transmitted as required by CMS.	F 640	Clinical Specialist for the facility on 7/24/2018. The MDS Nurse(s) will continue to prepare MDS assessments for transmission and will ensure appropriate assessments are split (only affects MA as payer). The Administrator will continue to transmit assessments, at least every 14 days for the foreseeable future; prior to transmitting, assessments will be checked to ensure MA claims are split properly. The validation report will be utilized as the tool to monitor compliance with MDS submission requirements; the Administrator or MDS nurse will ensure assessments are both transmitted and accepted. Transmission reports and Validation reports will be utilized as a monitoring tool to ensure regulatory compliance, a MDS representative (future MDS Coordinator or MDS Nurse) will be responsible for auditing the validation reports to ensure assessments are transmitted properly. Transmission reports and validation reports will be reviewed within 14 days of the MDS transmission for a period of 6 months. The MDS Coordinator or MDS Nurse will also be responsible for reporting the QA team's efforts at the Executive Quarterly QA meetings. The next scheduled Executive Quarterly QA meeting is scheduled for 7/31/2018. The Administrator will be responsible for implementing this portion of the plan of correction. The facility alleges compliance with all aspects of this portion of the plan of	

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F 640	Continued From page 16 On 7/12/18 at 1:45 PM, the Administrator was interviewed. He stated that he was presently responsible for transmitting the MDS assessments to the CMS system. The Administrator was unable to explain why the MDS assessment dated 4/23/18 for Resident #35 was not transmitted to the system.	F 640	correction as of 8/2/2018.	
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, observation, resident interview, and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of physical restraints (Resident #56), behaviors (Resident #64), falls (#24), and dental (#262) for 4 of 23 residents reviewed. The findings included: 1. Resident #56 was admitted to the facility on 4/30/17 and most recently readmitted on 1020/17 with diagnoses that included gastrostomy status and dementia with behavioral disturbance. A physician ' s order dated 11/9/17 indicated an abdominal binder for Resident #56. A physical restraint evaluation, undated, assessed Resident #56 ' s abdominal binder to determine if it was a physical restraint. The assessment indicated the abdominal binder had not prevented Resident #56 from accessing any portion of her body, it had not prevented/inhibited Resident #56 ' s mobility, and that Resident #56	F 641	To correct the deficiency cited, previously miscoded MDS entries were modified: restraint for resident #56 and dental for resident #262 were modified by the MDS Nurse; behavioral symptoms for resident #64 was modified by the Social Worker; a fall on resident #24 was unable to be modified (too late to modify 1/8/2018 assessment). Assessments that could be modified were resubmitted by the Administrator, assessment submission and transmission was confirmed by the Administrator on 8/2/2018. Using a root cause analysis, it was determined that the deficiency areas in question was a byproduct of a knowledge deficit by a MDS nurse (restraint was coded, but a restraint was not present), human error for behavior coding (Social Services employee) and human error for falls and dental (MDS nurse). To ensure no other restraint, behavior, fall, or dental coding errors existed, the MDS Nurse and Social	8/2/18

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F 641	Continued From page 17 was able to easily remove the binder independently. This assessment determined the abdominal binder for Resident #56 was not a physical restraint. The quarterly Minimum Data Set (MDS) assessment dated 4/30/18 indicated Resident #56 rarely/never understood and rarely/never understands. She was assessed with short-term and long-term memory problems, severely impaired decision making, and disorganized thinking. She had physical behaviors on 1 to 3 days, verbal behaviors on 1 to 3 days, and rejection of care on 1 to 3 days during the MDS review period. Resident #56 required the extensive assistance of 2 or more staff with bed mobility, transfers, dressing, and personal hygiene. She was assessed with no impairment of her upper and lower extremities. Resident #56 was coded to have "other" restraints used in chair or out of bed daily (defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident ' s body that the individual cannot remove easily which restricts freedom of movement or normal access to one ' s body). A physician ' s order dated 5/4/18 indicated the discontinuation of the abdominal binder for Resident #56. An interview was conducted with Nurse # 4 on 7/11/18 at 3:20 PM. She reported Resident #56 previously had an abdominal binder that was implemented to cover the area of her stomach where her gastrostomy tubing was connected. She indicated the abdominal binder was not a physical restraint for Resident #56 as she was	F 641	Workers audited all MDS assessments for the current quarter as that was the specific deficiencies cited, the audit was complete as of 7/25/2018. No other errors were identified during that audit process by administrative nursing team members. The MDS Coordinator, responsible for the restraint coding error is no longer employed by the facility. The Director of Nurses provided and in-service to the MDS Nurse on 7/31/2018 to ensure MDS assessment accuracy related to restraints, behaviors, falls, and dental. The facility created a new QA team, The 2018 Annual Survey Plan of Correction QA Team, to implement the plan of correction. The updated process/procedure for verifying the accuracy of the full MDS assessment was in-serviced to the MDS (and other administrative staff members) by the Administrator on 7/27/2018. A new QA tool (“MDS Assessments Accuracy Tracking Log”) was designed and in-serviced to this same group as well. The internal process/procedure now calls for the full MDS assessments to be audited prior to submission/transmission; additionally, the MDS nurse completing the assessment will no longer be allowed to audit/accuracy check their own work. The facility has 2 MDS nurses and they will only audit the specified MDS assessments of their co-worker(s). The internal QA audits for coding accuracy will increase the facility’s ability to catch any MDS coding error prior to that point. The 2018 Annual Survey Plan of Correction	

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F 641	Continued From page 18 able to remove the abdominal binder independently. An interview was conducted with the Director of Nursing (DON) on 7/11/18 at 4:41 PM. Resident #56 ' s physician ' s orders for the abdominal binder, the physical restraint evaluation, and the MDS assessment dated 4/30/18 that coded Resident #56 with a physical restraint used daily was reviewed with the DON. The DON revealed the MDS was coded inaccurately for physical restraints. She stated that a former MDS Nurse coded this assessment for physical restraints. She reported this former MDS Nurse ceased her employment at the facility on 6/1/18. An interview was conducted with the current MDS Nurse on 7/12/18 at 11:40 AM. Resident #56 ' s physician ' s orders for the abdominal binder, the physical restraint evaluation, and the MDS assessment dated 4/30/18 that coded Resident #56 with a physical restraint used daily was reviewed with the MDS Nurse. The MDS Nurse confirmed the DON ' s report that Resident #56 ' s 4/30/18 MDS was coded inaccurately for physical restraints. A follow up interview was conducted with the DON on 7/12/18 at 12:25 PM. She reported her expectation was for the MDS to be coded accurately. 2. Resident #64 was most recently admitted to the facility on 8/18/17 with multiple diagnoses that included dementia with behavioral disturbance. The quarterly Minimum Data Set (MDS) assessment dated 5/6/18 indicated Resident #64	F 641	QA Team will next meet on 8/3/2018. The 2018 Annual Survey Plan of Correction QA team will meet weekly and will use the MDS Assessment Accuracy Tracking Log to guide their monitoring efforts. The 2018 Annual Survey Plan of Correction QA team will meet weekly for a minimum of the next 6 months and will meet monthly thereafter to ensure the plan of correction remains in compliance with regulations. During the QA meetings, the log of completed/audited MDS assessments will be reviewed by the team members to ensure auditing and accuracy efforts remain in place are effective as well. The MDS Coordinator or MDS Nurse will be responsible for bringing the log (including any supporting documentation) to the QA meetings. The MDS Coordinator will also be responsible for reporting the QA team's efforts at the Executive Quarterly QA meetings. The next scheduled Executive Quarterly QA meeting is scheduled for 7/31/2018. The MDS Nurse for the facility will be responsible for implementing this portion of the plan of correction. The facility alleges compliance with all aspects of this portion of the plan of correction as of 8/2/2018.	

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rarely/never understood and rarely/never understands. She was assessed with short-term and long-term memory problems, and severely impaired decision making.

Section E, the Behavior Section, indicated Resident #64 had other behavioral symptoms 1 to 3 days during the seven-day MDS look back period (4/30/18 through 5/6/18). Section E of this MDS was completed by Social Worker (SW) #1.

A review of the Behavior Monitoring Record during the seven day look back period of the 5/6/18 quarterly MDS (4/30/18 through 5/6/18) for revealed Resident #56 exhibit "picking at skin" behaviors on 4/30, 5/1, 5/2, 5/3, 5/4, and 5/6. A nursing note dated 5/1/18 indicated Resident #56 was observed pulling pieces of her hair out.

An interview was conducted with SW #1 on 7/11/18 at 10:08 AM. She stated she reviewed the behavior monitoring record and nursing notes to code Section E of the MDS assessments. She confirmed she completed Section E of Resident #64 ' s 5/6/18 MDS assessment. This section of Resident #56 ' s MDS that indicated she had other behavioral symptoms on 1 to 3 days was reviewed with SW #1. The behavior monitoring record and nursing notes that indicated Resident #56 had other behavioral symptoms on 6 of 7 days was reviewed with SW #1. She revealed Resident #56 ' s 5/6/18 MDS was coded inaccurately for behaviors. She stated this was an error and that the MDS should have been coded as other behavioral symptoms on 4-6 days.

An interview was conducted with the Director of Nursing (DON) on 7/12/18 at 12:25 PM. She

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reported her expectation was for the MDS to be coded accurately.

3. Resident #24 was originally admitted to the facility on 1/18/17 with multiple diagnoses including end stage renal disease (ESRD). The quarterly Minimum Data Set (MDS) assessment dated 1/8/18 and the annual MDS assessment dated 4/10/18 indicated that Resident #24 had no falls.

Review of the nurse's notes and the incident report dated 1/2/18 revealed that Resident #24 had a fall and sustained bruises to her left forehead and left upper back.

On 7/12/18 at 11:50 AM, the MDS Nurse was interviewed. She stated that she started as MDS Nurse in October 2017 and she was still learning. She reviewed the quarterly and the annual MDS assessments and verified that the quarterly MDS dated 1/18/18 would have been coded for fall with injury.

On 7/12/18 at 12:30 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS assessments to be accurate.

4. Resident # 262 was admitted 6/21/18 with cumulative diagnoses of Atrial Fibrillation and Hypertension.

Review of Resident #262's care plan dated 6/22/18 indicated she wore partial dentures and was to have a dental consult as needed or requested.

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F 641	Continued From page 21 Resident #262's admission Minimum Data Set (MDS) dated 6/28/18 indicated she was cognitively intact. She was coded as having no dental issues or concerns. Observation and interview was conducted on 7/11/18 at 11:56 AM. Resident #262 confirmed she wore an upper partial and voice no concerns with the partial. Observation of bottom front teeth revealed extreme wearing down of her teeth. There was noted missing teeth on the back of her lower gums. She stated her bottom front teeth have been painful in past but were not painful at present. Resident #262 stated she was not aware of any facility dental services. In an interview on 7/12/18 at 11:35 AM, the MDS Nurse stated the dental assessment for Resident #262 was inaccurately coded by the Dietary Manager (DM). She stated the DM was on vacation and not available for interview. The MDS Nurse stated the admission MDS dated 6/28/18 should be an accurate reflection of Resident #262's actual dental status and services provided if needed or requested. In an interview on 7/12/18 at 12:26 PM, The Director of nursing stated it was her expectation that the admission MDS dated 6/28/18 accurately reflect Resident #262's oral and dental status.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of	F 657		7/31/18

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(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 657	Continued From page 22 the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident interview, and staff interview, the facility failed to review and revise plans of care related to an abdominal binder (Resident #56), dialysis (Resident #24), and contractures (Resident #51) for 3 of 23 residents reviewed. The findings included: 1. Resident #56 was admitted to the facility on 4/30/17 and most recently readmitted on 10/20/17 with diagnoses that included gastrostomy status and dementia with behavioral disturbance. A physician ' s order dated 11/9/17 indicated an	F 657	To correct the deficiency cited, care plans for residents were updated by the MDS Nurse by 7/31/2018: restraint use on resident #56 was removed, permacath for resident #24 was removed, and elbow splint device for resident #51 was added. Using root cause analysis it was determined that necessary care plan updates were not achieved due to one of two reasons: human error or a knowledge deficit by a MDS nurse; necessary care plan updates were not caught within the interdisciplinary team. To ensure there are no other care plan errors specific to	

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F 657	Continued From page 23 abdominal binder for Resident #56. A physical restraint evaluation, undated, assessed Resident #56 ' s abdominal binder to determine if it was a physical restraint. The assessment indicated the abdominal binder had not prevented Resident #56 from accessing any portion of her body, it had not prevented/inhibited Resident #56 ' s mobility, and that Resident #56 was able to easily remove the binder independently. This assessment determined the abdominal binder for Resident #56 was not a physical restraint. The quarterly Minimum Data Set (MDS) assessment dated 4/30/18 indicated Resident #56 rarely/never understood and rarely/never understands. She was assessed with short-term and long-term memory problems, severely impaired decision making, and disorganized thinking. A physician ' s order dated 5/4/18 indicated the discontinuation of the abdominal binder for Resident #56. The plan of care for Resident #56, updated on 5/4/18, indicated Resident #56 had an abdominal binder. The interventions included, in part, monitor for skin integrity every shift under binder (onset 2/3/18, reviewed and continued 5/3/18) and remove binder and assess every shift and per facility policy (onset 2/3/18, reviewed and continued 5/3/18). An interview was conducted with Nurse # 4 on 7/11/18 at 3:20 PM. She reported Resident #56 previously had an abdominal binder that was	F 657	restraints, permacaths, or splint devices, all resident's care plans were audited for the current quarter as that was the specific deficiencies cited; the audit was completed by 7/31/2018 by the interdisciplinary team, which includes: MDS nurse, Social Workers, Director of Nurses, and Administrator. No other errors were identified during that audit process by the MDS staff or interdisciplinary team. The facility created a new QA team, The 2018 Annual Survey Plan of Correction QA Team, to implement the plan of correction. The updated process/procedure for verifying the accuracy of the resident's plan of care was in-serviced to the MDS nurses (and other administrative staff members) by the Administrator on 7/27/2018. A new QA tool ("Care Plan Accuracy Tracking Log") was designed and in-serviced to this same group as well; the log will be utilized to ensure care plan accuracy for restraints, permacaths, and splint devices; the MDS Nurse completed initial audits, using the care plan accuracy tracking log by 7/31/2018. The internal process/procedure requires that care plans be updated during the MDS assessment process, as physician orders change, and when other care requirements change. The MDS nurses will be responsible for ensuring care plans for specific nursing (restraint and permacath) and therapy devices (splints) are accurate and timely. The MDS staff members will only audit the specified care	

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F 657	Continued From page 24	F 657		

implemented to cover the area of her stomach where her gastrostomy tubing was connected. She indicated Resident #56 ' s abdominal binder had been discontinued over 2 months ago.

An interview was conducted with the MDS Nurse on 7/12/18 at 11:40 AM. The care plan that indicated Resident #56 had an abdominal binder and the physician ' s order that discontinued the abdominal binder on 5/4/18 was reviewed with the MDS Nurse. The MDS Nurse revealed she discontinued the care plan related to abdominal binder for Resident #56 yesterday afternoon (7/11/18). She indicated this care plan should have been revised after the discontinuation of the abdominal binder on 5/4/18.

An interview was conducted with the Director of Nursing on 7/12/18 at 12:25 PM. She reported her expectation was for care plans to be reviewed and revised to reflect the current status of the residents.

2. Resident #24 was originally admitted to the facility on 1/18/17 with multiple diagnoses including end stage renal disease (ESRD). The annual Minimum Data Set (MDS) assessment dated 4/10/18 indicated that Resident #24 had moderate cognitive impairment and she was receiving dialysis.

Resident #24's care plan dated 4/12/18 was reviewed. One of the care plan problems was resident had diagnoses of ESRD and was receiving dialysis. The goal was for the resident to have no complications from the hemodialysis. One of the care plan approaches included to assess the permacath (a catheter/tubing inserted into the jugular vein and used for hemodialysis)

plan update areas of one another, meaning they will not audit their own work. The internal QA audits for care plan accuracy will increase the facility's ability to catch any care plan errors more timely. The 2018 Annual Survey Plan of Correction QA Team will next meet on 8/3/2018.

The 2018 Annual Survey Plan of Correction QA team will meet weekly and will use the Care Plan Accuracy Tracking Log to guide their monitoring efforts. The 2018 Annual Survey Plan of Correction QA team will meet weekly for a minimum of the next 6 months and will meet monthly thereafter to ensure the plan of correction remains in compliance with regulations. During the QA meetings, the log of care plan revisions will be reviewed by the team members to ensure auditing and accuracy efforts remain in place are effective as well. The MDS Coordinator or designee will be responsible for bringing the log (including any supporting documentation) to the QA meetings. The MDS Coordinator will also be responsible for reporting the QA team's efforts at the Executive Quarterly QA meetings. The next scheduled Executive Quarterly QA meeting is scheduled for 7/31/2018.

The MDS Nurse (Care Plan Coordinator) for the facility will be responsible for implementing this portion of the plan of correction.

The facility alleges compliance with all aspects of this portion of the plan of

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F 657	Continued From page 25 site for infection or bleeding. Review of the nurse's notes dated 4/19/18 revealed that the resident's permacath on the right chest wall was removed on 4/19/18. On 7/10/18 at 3:26 PM, Resident #24 was observed. She has an AV (arteriovenous) fistula (a connection between an artery and a vein and used for hemodialysis) on her right arm. On 7/12/18 at 11:50 AM, the MDS Nurse was interviewed. She stated that she started as MDS Nurse in October 2017 and she was still learning. She stated that she did not receive a copy of the doctor's order to discontinue the permcath so she didn't know that it was already removed. On 7/12/18 at 12:30 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the care plan to be reviewed and revised to reflect the resident's current status. 3. Resident #51 was admitted to the facility 9/8/17. Cumulative diagnoses included hemiplegia (weakness) and hemiparesis (paralysis) following a cerebrovascular accident (CVA) affecting the left side. A quarterly Minimum Data Set (MDS) dated 4/26/18 indicated Resident #51 was cognitively intact. The occupational therapy discharge summary dated 3/22/18 indicated Resident #51 received occupational therapy services to increase external rotation of his left shoulder by 10 degrees. The goal status was not met on 3/22/18 with increased external rotation of left shoulder improved by 5 degrees. Staff applied orthotic	F 657	correction as of 7/31/2018.	

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device to left upper extremity with no complaints of pain. Discontinue therapy services and Resident #51 was placed on the restorative nursing program on 3/26/18.

Restorative Program caregiver instructions stated the restorative program would begin on 3/26/18. Activities to be performed with resident: Resident #51 would tolerate passive range of motion to the left upper extremity at all joints with gentle prolonged stretch to elbow extension 2 times/ 10 each. Apply elbow splint to left upper extremity with a goal of Resident #51 to tolerate application of elbow splint up to six hours. Complete skin check before and after removal of splint. Frequency of restorative program was six times a week x 1 month.

A review of restorative nursing notes revealed Resident #51 received restorative nursing services from 3/26/18 through 4/27/18 for passive range of motion to left upper extremity with gentle prolonged stretch to elbow extension 2 x 10 each, splinting to apply elbow splint to left upper extremity with the goal to tolerate the left elbow splint up to six hours. The last restorative nursing note was dated 4/24/18 and stated Resident #51 would tolerate passive range of motion to left upper extremity at all joints with gentle prolonged stretch to elbow extension at 2x/10 each. Resident tolerated/ allowed passive range of motion to left upper extremity at all joints with gently prolonged stretches to elbow extension 2 x 10 each. Continue passive range of motion with restorative nursing therapy to prevent decline.

A review of the care plan for Resident #51 last reviewed on 4/30/18 revealed there was no care plan for contracture management or any

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F 657	Continued From page 27	F 657		

interventions noted for the use of a left elbow splint for management of the left elbow contracture.

On 7/11/18 at 11:45 AM, an interview was conducted with the Director of Nursing who stated she oversaw the restorative program. She said Resident #51 had been in the restorative program and he was discontinued from the restorative program on 4/24/18. She said residents received restorative nursing for a set amount of time usually 1-3 months and then could possible remain on a maintenance program done by the nursing assistants. She stated she would have to check about Resident #51 receiving passive range of motion by the nursing assistant.

On 7/11/18 at 4:24 PM, an interview was conducted with the Director of Nursing She said Resident #51 was placed on the restorative nursing program 10/23/17 for the use of the left elbow splint. Resident #31 complained of pain from the left elbow splint and was referred back to occupational therapy 12/28/17. Occupational therapy assessed Resident #51 on 1/2/18 and resumed occupational therapy on 1/4/18. He was discharged from occupational therapy 3/26/18 to restorative nursing for one month for passive range of motion to the left upper extremity all joints with gentle prolonged stretch to elbow. Restorative nursing was to apply the elbow splint. After one month, Resident #51 discontinued restorative nursing for the left elbow splint. He was transferred to the nursing assistants on the floor for the passive range of motion and application of the left elbow splint. The Director of Nursing stated the Minimum Data Set (MDS) Coordinator was responsible for the care plan and Resident #51 should have a care plan in

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F 657	Continued From page 28 place for contractures and the use of the elbow splint. On 7/12/18 at 8:35 AM, an interview was conducted with Resident #51. He stated he wore the left elbow splint during the day for a few hour and nursing staff applied the left elbow splint every day. On 7/12/18 at 11:37 AM, an interview was conducted with the MDS Nurse. She said she added the use of the left elbow splint to the care plan 7/11/18 after she was made aware that Resident #51 wore a left elbow splint.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility failed to assist a resident requiring extensive assistance with personal hygiene for 1 (Resident #18) of 1 reviewed for activities of daily living (ADLs). The findings included: Resident #18 was admitted on 9/14/16 with cumulative diagnosis of Hypertension, Depression and Chronic Obstructive Pulmonary Disease. Resident #18's quarterly Minimum Data Set (MDS) dated 3/31/18 indicated he was cognately intact and exhibited no behaviors. Resident #18	F 677	Resident #18 normally receives non-daily personal hygiene care on his routinely scheduled shower days and as needed. The Certified Nursing Assistant (CNA) for this resident's assignment failed to provide specifically mentioned Activity of Daily Living (ADL) care on 7/10/2018. The department leader responsible for making rounds on this resident's assignment did not notice the resident needing to be shaven or nails needing trimming. Resident received ADL care on 7/11/18 per surveyor's notes. Through the facility rounding assignments, all other residents	7/31/18

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F 677	Continued From page 29 was coded for extensive staff assistance with his personal hygiene. Review of Resident #18's last revised care plan dated 4/3/18 indicated he required staff assistance with his ADLs due to his cardiovascular status. There was no care plan indicating Resident #18 refused ADL assistance. Observation and interview was conducted with Resident #18 on 7/9/18 at 12:36 PM. He was unshaven and presented with long fingernails. Resident #18 stated it was his desire to be clean shaven and have his fingernail trimmed. He stated he required the assistance of staff to shave and trim his fingernails. Observation and interview was conducted with Resident #18 on 7/10/18 at 7:47 AM. He was unshaven and his fingernails were untrimmed. He stated maybe someone would help him shave and cut his nails today. He stated he did not like to ask the staff because they were so busy. Interview on 7/10/18 at 9:45 AM, Nursing Assistant (NA) #1) stated she was assigned Resident #18 and "washed him up this morning". She stated he was always cooperative with his care and was not known to refuse ADL assistance. Observation and interview was conducted on 7/11/18 at 7:55 AM. He was sitting up in the bed eating breakfast. He was unshaven and his fingernails were untrimmed. He stated "they just hadn't gotten around to it yet. Hopefully, they will	F 677	were visualized by department leaders responsible for the individual rounding assignments to ensure neat and clean appearance with facial hair and nail care being provided; visual audits were completed by 7/25/2018. The Administrator completed inspections on 7/25/2018 and 7/27/2018, resident #18 was noted to be clean shaven and having adequate nail care. All full time, part time, and PRN (“as needed”) nursing staff members have been in-serviced by the Director of Nurses of proper ADL requirements, specific to shaving and nail care; nurses or CNAs not in-serviced prior to 7/31/2018 will be in-serviced at the beginning of his/her next scheduled shift. The facility created a new QA team, The 2018 Annual Survey Plan of Correction QA Team, to implement the plan of correction. The updated process/procedure for completing ADL care as specifically cited was in-serviced to Nurses and CNAs were by the DON by 7/31/2018. A monitoring tool, “Shower Audit Tool” was created to ensure showers and cited ADL tasks are provided per the facility expectation. The monitoring tool will be completed on all residents by the CNA assigned to this resident for one calendar year; the nurse assigned to this resident will initial that care was provided by the CNA. The tool will be adjusted as needed to ensure compliance with regulatory requirements. The Wound Care Nurse will bring completed Shower Audit Tools to the weekly QI meetings; the monitoring tool	

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F 677	Continued From page 30 do it today." Observation and interview was conducted on 7/11/18 at 9:11 AM. Resident #18 was dressed and sitting up in his wheelchair. He was clean shaven but his fingernails were still untrimmed. He stated he received a shower this morning and the aide shaved him but didn't mention anything about trimming his nails. He stated he did not request the aide to trim his nails. In an interview on 7/11/18 at 11:32 AM, NA #1 stated she showered and shaved Resident #18 this morning. She stated Resident #18 preferred to be clean shaven. NA #1 stated she did not noticed that his fingernails were long and untrimmed. She stated she normally trims his fingernails every two weeks. She stated Resident #18 was cooperative with having his fingernails trimmed and he was not prone to ask for assistance because he does not like to ask for assistance. NA #1 stated Resident #18 should not have to ask to be clean shaven or have his fingernails trimmed since it was the staff responsibility to assist him with his ADLs. Observation and interview was conducted on 7/11 at 3:47 PM. Resident #18's fingernails had been trimmed. He stated the aide trimmed his fingernails earlier today. He stated he felt much better. In an interview on 7/12/18 at 12:26 PM, the Director of Nursing stated it was her expectation that Resident #18 receive ADL assistance as needed.	F 677	will be reviewed weekly for 3 months then monthly thereafter. The Director of Nurses and interdisciplinary team will be responsible for noting any trends in care and making adjustments to the residents plan of care as needed. The Director of Nurses will be responsible for reporting the QA team's efforts at the Executive Quarterly QA meetings. The next scheduled Executive Quarterly QA meeting is scheduled for 7/31/2018. The Director of Nurses for the facility will be responsible for implementing this portion of the plan of correction. The facility alleges compliance with all aspects of this portion of the plan of correction as of 7/31/2018.	
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		7/31/18

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F 684	Continued From page 31 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, resident and staff interviews the facility failed to obtain a physician order for compression hose for one of one residents with lower leg edema (resident #45) and failed to obtain a physician order for the use of a left elbow splint for one of one residents reviewed for contractures (Resident #51). The findings included: 1. Resident #45 was admitted to the facility on 9/8/17. Cumulative diagnoses included: nontraumatic intracerebral (brain) hemorrhage, cerebral infarction, chronic kidney disease stage 3, atrial fibrillation (irregular heart rhythm) and shortness of breath. A quarterly Minimum Data Set (MDS) dated 4/21/18 indicated Resident #45 was cognitively intact. She required extensive assistance with dressing, personal hygiene and bathing. A Nurse Practitioner note dated 5/8/18 noted that Resident #45 had trace edema noted to bilateral lower extremities. Plan: compression stockings bilateral lower extremities. A Nurse Practitioner note dated 7/9/18 indicated	F 684	The Nurse Practitioner (NP) order for compression stockings for resident #45 could not be located or verified. Therapy transferred resident #51 to restorative nursing, then to floor staff for splinting; during this transfer process from therapy trials to restorative nursing the order was not obtained. Resident #45 has an order for compression stockings in the Treatment Administration Record (TAR). Resident #51 has an order for the left elbow splint in the TAR. The NP was requested to write orders when she is in the facility as opposed to expecting staff to retrieve potential orders from her documentation. Therapy will write orders for orthotic devices once therapy staff initiates treatment or trials of orthotic devices. The facility created a new QA team, The 2018 Annual Survey Plan of Correction QA Team, to implement the plan of correction. Full time, part time, and PRN (“as needed”) nurses were in-serviced of the facility expectation to ensure orders are obtained for devices (compression	

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F 684	Continued From page 32 Resident #45 had compression stockings for bilateral lower extremities. On 7/9/19 at 3:13 PM, an observation of Resident #45 revealed Resident #45 had edema of both lower extremities. Bilateral compression stockings were observed. A review of the physician orders revealed no order noted for the application and use of bilateral compression hose. A review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) for the months of May 2018, June 2018 and July 2018 revealed no documentation regarding the application of bilateral compression hose. On 7/11/18 at 11:30 AM, Resident #45 was sitting in her wheelchair in the hallway. She was wearing bilateral compression hose and said the nursing assistant put them on. An observation of her ankles, feet and lower legs showed a decrease in edema from the initial observation on 7/9/18. On 7/11/18 at 2:15 PM, an interview was conducted with NA #4 who stated she provided care for Resident #45 on a regular basis. She stated she assisted Resident #45 with dressing and putting her compression hose on. NA #4 said Resident #45 sometimes refused to put the compression hose on and stated they hurt her legs. If she refused to have them put on. NA #4 said she informed the nurse but it was rare for Resident #45 to refuse. On 7/11/18 at 4:24 PM, an interview was	F 684	stocking and orthotic devices) used within the facility by the Director of Nurses as of 7/31/2018; nurses not in-serviced prior to 7/31/2018 will be in-serviced at the beginning of his/her next scheduled shift. The NP was educated by the Clinical Specialist on 7/24/2018 of the facility expectation to write orders while in the facility caring for residents. If the NP is working remotely, then a verbal order would be the acceptable expectation. The Therapy Manager and licensed Therapists were also educated of the expectation to write orders once treatment is initiated or trialed for orthotic devices utilized by residents. A monitoring tool, “Compression Stocking and Orthotic Device Auditing Tool” was created to ensure orders are obtained for devices utilized by residents in the facility. The monitoring tool will be completed on all residents for 6 months by the Wound Care Nurse. The Wound Care Nurse will bring completed Compression stocking and Orthotic device Auditing Tools to the weekly QI meetings; the monitoring tool will be reviewed weekly for 3 months then monthly thereafter. The Director of Nurses and interdisciplinary team will be responsible for noting any order omissions as related to compression stockings or orthotic devices. The Director of Nurses will be responsible for reporting the QA team’s efforts at the Executive Quarterly QA meetings. The next scheduled Executive Quarterly QA meeting is scheduled for 7/31/2018.	

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F 684	Continued From page 33 conducted with the Director of Nursing who stated a physician ' s order should have been written for the compression hose and the use of the compression hose should have been placed on the MAR/ TAR to monitor and document that the compression hose was applied. On 7/12/18 at 9:22 AM, an interview was conducted with the Nurse Practitioner. She stated if she had included in her plan of care on 5/8/18 and 7/9/18, she had given an order for the use of the compression hose and there should have been a physician order written for Resident #45 ' s compression hose. 2. Resident #51 was admitted to the facility 9/8/17. Cumulative diagnoses included hemiplegia (weakness) and hemiparesis (paralysis) following a cerebrovascular accident (CVA) affecting the left side. A quarterly Minimum Data Set (MDS) dated 4/26/18 indicated Resident #51 was cognitively intact. Limited range of motion was noted for the upper and lower extremities on one side. A review of restorative nursing notes revealed Resident #51 received restorative nursing services from 3/26/18 through 4/27/18 for passive range of motion to left upper extremity with gentle prolonged stretch to elbow extension 2 x 10 each, splinting to apply elbow splint to left upper extremity with the goal to tolerate the left elbow splint up to six hours. The last restorative nursing note was dated 4/24/18 and stated Resident #51 would tolerate passive range of motion to left upper extremity at all joints with gentle prolonged stretch to elbow extension at 2x/10 each. Resident tolerated/ allowed passive range of	F 684	The Director of Nurses will be responsible for ensuring compliance with this plan of correction. The facility alleges compliance with this plan of correction on 7/31/2018.	

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F 684	Continued From page 34 motion to left upper extremity at all joints with gently prolonged stretches to elbow extension 2 x 10 each. Continue passive range of motion with restorative nursing therapy to prevent decline. A review of physician ' s orders for July 2018 revealed there was no physician ' s orders for the use of the left elbow splint. On 7/11/18 at 4:24 PM, an interview was conducted with the Director of Nursing who stated Resident #51 should have had a physician ' s order written for the use/ application of the left elbow splint and the use of the left elbow splint should have been placed on the Treatment Administration Record (TAR) for monitoring. On 7/12/18 at 7:30 AM, a second interview was conducted with the Director of Nursing. She stated she had spoken to Resident #51 and he had been getting the elbow splint at night and the hand splint during the day. She said the piece that was missing was the physician order for the elbow splints and the monitoring of the splints on the TAR. On 7/12/18 at 8:35 AM, an interview was conducted with Resident #51 who stated nursing staff had been applying the left elbow splint daily.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate	F 689		7/31/18

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F 689	Continued From page 35 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident interview, and staff interview, the facility failed to prevent a resident from falling out of bed during a bed bath when one staff provided assistance for a resident who was dependent on two or more staff for bathing (Resident #9) and failed to implement fall interventions for a resident at high risk for falls (Resident #39). This was for 2 of 4 residents reviewed for accidents. The findings included: 1. Resident #9 was admitted to the facility on 3/15/16 and most recently readmitted on 3/12/18 with diagnoses that included heart failure, obesity, muscle weakness, and dementia. The quarterly Minimum Data Set (MDS) assessment dated 6/22/18 indicated Resident #9 had clear speech and she had the ability understand others and be understood by others. She was noted with short term and long-term memory problems. Resident #9 had no behaviors and no rejection of care. She was dependent on 2 or more staff with bathing (full body bath, shower, or sponge bath), dressing, and personal hygiene and she required the extensive assistance of 2 or more staff with bed mobility and toileting. Resident #9 was assessed as not steady on her feet and only able to stabilize with staff assistance. She had impairment on both sides of her upper and lower extremities. The plan of care for Resident #9 included the	F 689	To correct the deficiency, the facility administrative team spoke with staff regarding utilization of the CNA (Certified Nursing Assistant) POCs devices (Point of Care documentation device). CNAs and nurses confirmed that the process of the facility is to distribute the POCs devices at the start of the CNA's shift, after assignments have been generated in the Electronic Medical Record (EMR) CNA assign module. No staff members identified late provision of the devices to be a chronic problem. It was also identified during the survey process that the CNA fall intervention communication tool in the CNA book was not updated to include all fall interventions. The facility created a new QA (Quality Assurance) team, The 2018 Annual Survey Plan of Correction QA Team, to implement the plan of correction. The facility's 2018 Annual Survey Plan of Correction QA team evaluated changes that could be made to the current process to better assist staff with identifying specific resident needs prior to the start of care. The team initiated a plan to ensure that CNAs are provided with the POCs devices at the beginning of their shift, prior to the acceptance of one's assignment. An audit was conducted during the weekly QI (Quality Indicator) meeting to identify any further interventions that might not have been	

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F 689	Continued From page 36 care area of a self-care deficit requiring assistance with all Activity of Daily Living (ADL) care related to a functional decline, receipt of hospice services, and decreased range of motion in all extremities. This care area was last revised on 7/2/18. The interventions, also updated on 7/2/18, included bathing assistance as needed and honoring Resident #9 ' s request for a bed bath instead of showers. An incident report dated 7/5/18 indicated Resident #9 had a witnessed fall in her room during routine morning care on 7/5/18 at 9:38 AM. Nursing Assistant (NA) #3 was a witness to the fall. The narrative of the incident indicated NA #3 was assisting Resident #9 with a bed bath and morning care at the time of the fall. NA #3 reported that during care, Resident #9 got close to the edge of the bed, she (NA #3) attempted to assist resident back to the center of the bed, and resident "slipped" off the bed due to NA #3 being unable to catch her. Resident #3 was noted with minor injuries described as skin tears to her right and left hands. A Nurse Practitioner note dated 7/9/18 indicated nursing staff reported to her that Resident #9 was turned over by an NA and rolled out of bed. An NA Care guide, accessible on the Point of Care (POC) handheld electronic device, for Resident #9 was reviewed on 7/10/18. This care guide was undated. The care guide indicated Resident #9 was dependent on 2 or more staff with bed mobility and bathing (including bed baths and showers). Resident #9 was also dependent on 2 or more staff and a mechanical lift for transfers.	F 689	added to the fall intervention communication tool. No other interventions were identified as omissions to the tool. To monitor for plan of correction effectiveness and compliance, the 2018 Annual Survey Plan of Correction QA team created and implemented a 100% nursing staff in-service to ensure education of all staff. This in-service was completed with all full time and part time nursing staff by 7/31/18. All PRN (“as needed”) staff members were in-serviced with the LG communication module to ensure all staff were in-serviced prior to the start of his/her next scheduled shift. Nurses are now required to provide each CNA with a POCs device at the start of their shift. Devices are to be provided prior to completion of the CNA assign module in LG. This will ensure that CNAs have access to all pertinent resident care information at the start of their shift and prior to providing care. The Survey Plan of Correction QA team, with the assistance of the QA nurse and Unit Manager, in-serviced all nurses that each intervention implemented to assist with preventing falls should be added to the Fall Intervention Communication Tool at the point of initiation. These updates will be handwritten on the tool to ensure that each new intervention is communicated with the CNAs and other nursing staff effectively. The QA nurse will be responsible for updating the Fall Intervention Communication Tool weekly. The CNA POCs device will also be	

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F 689	Continued From page 37 An interview was conducted with NA #3 on 7/10/18 at 2:10 PM. She stated she had worked at the facility for close to a year. She revealed she had not worked with Resident #9 prior to her assignment on 7/5/18. NA #3 was asked to describe the events that occurred on 7/5/18 when Resident #9 fell out of bed during her bed bath. NA #3 stated that normally at the beginning of each shift the nurse on the unit handed out a POC (handheld electronic device) to each NA on the unit. She explained that the POC device contained a list of all of the residents assigned to the NA as well as the interventions/care needs required for each of assigned residents. NA #3 stated that on 7/5/18 she had come on shift around 6:45 AM and Nurse #5 was assigned to her unit. She explained that Nurse #5 was relatively new to the facility and she had not assigned the POC devices and handed them out at the beginning of the shift as per normal procedure. She indicated that at the time she began Resident #9 ' s morning care and bed bath on 7/5/18 she had not received her POC device. NA #3 indicated she assisted Resident #9 with her morning care and bed bath without assistance from another staff member on 7/5/18. She stated that during the bed bath as she was turning Resident #9, the resident got close to the edge of the bed, she tried to assist her back to the center of the bed, but the resident fell forward onto the floor and she was unable to stop her from falling. She reported that she immediately got a nurse to assess Resident #9 and she had minor injuries described as skin tears to her hands. This interview with NA #3 continued. She stated that after Resident #9 ' s fall on 7/5/18 she obtained her POC device and reviewed Resident	F 689	updated at the start of the next business day to ensure effective communication. Increased intervention monitoring at the point of care, coupled with the re-education for the nursing staff will promote and ensure compliance. The monitoring efforts will be turned in and reviewed during the 2018 Annual Survey Plan of Correction QA team meetings. The QA team will meet weekly for a minimum of the next 6 months and will meet monthly thereafter to ensure the plan of correction remains in compliance with regulations. Any additional changes or improvements necessary to ensure continued compliance will be reflected in the notes of the weekly QA team meetings. The audits and analysis results will also be reported by the DON at the Executive Quarterly QA meeting. The next scheduled Executive Quarterly QA meeting is scheduled for 7/31/2018. The Director of Nursing will be responsible for implementing this portion of the plan of correction. The facility alleges compliance with all aspects of this portion of the plan of correction by 7/31/2018.	

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#9 ' s care needs. She reported that the POC device indicated Resident #9 was a 2 person assist and required a mechanical lift for transfers. She revealed she should not have been providing care that included repositioning and bed mobility without another staff member present. NA #3 stated that if she had reviewed the POC device prior to providing care to Resident #9 she would have had another NA assist her with Resident #9 ' S bed bath.

An interview was conducted with Nurse #4 on 7/10/18 at 2:50 PM. She reported she was very familiar with Resident #9. She stated that Resident #9 had been a 2 person assist prior to and after the 7/5/18 fall for any bed bath that involved repositioning and/or turning. She explained that if staff was just providing a half bed bath that had not required repositioning and/or turning that 1 staff member could have been used at the time of the 7/5/18 fall. Nurse #4 was asked what the normal procedure was for distributing the POC devices to the NAs. She stated that at the beginning of each shift she assigned the residents to NAs on her electronic system that linked to the POC devices. She reported that after she completed the NA assignments the POC devices were distributed to the NAs. She indicated that the purpose of the POC device was so that each NA knew what type of care and assistance needs each resident had.

An interview was conducted with the Staff Development Coordinator (SDC) on 7/10/18 at 3:10 PM. She stated that she was responsible for reviewing all falls, completing investigations, and root cause analyses. She reported that she was not working on 7/5/18 and had not returned to

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work until 7/9/18. She indicated she reviewed Resident #9 ' s 7/5/18 fall on 7/9/18. The SDC was asked if she had investigated the fall and determined a root cause analysis. She confirmed Resident #9 required a 2 person assist for bed baths that involved any repositioning and/or turning. She revealed that NA #3 should not have been providing this care to Resident #9 without another staff member present. She additionally revealed that NA #3 had not received and/or reviewed the POC device prior to providing care to Resident #9 on 7/5/18. The SDC stated that the nurse on the unit should be assigning and distributing the POC devices at the beginning of each shift. SDC indicated she had phoned Nurse #5, the nurse assigned to Resident #9 ' s unit on 7/5/18 at the time of the fall, but she had not heard back from her as of this time.

A phone interview was conducted with Nurse #5 on 7/10/18 at 3:40 PM. Nurse #5 stated that she began working at the facility on 5/26/18, but she had just recently completed her orientation. She stated that during orientation she was instructed to assign the POC devices and distribute them to the NAs at the beginning of each shift. She explained that the POC device was where the NAs looked to determine what type of assistance each resident required for their ADLs. Nurse #5 confirmed she was working on Resident #9 ' s unit at the time of her 7/5/18 fall. She additionally confirmed she had not assigned and distributed the POC devices to the NAs at the beginning of their shift. She stated that after the 7/5/18 fall for Resident #9 the Director of Nursing (DON) reminded her that the facility ' s normal procedure was for the POC devices to be assigned and distributed to the NAs at the beginning of each shift.

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An interview was conducted with the DON on 7/10/18 at 3:55 PM. She stated she was working on 7/5/18 at the time of Resident #9 ' s fall. She indicated she interviewed NA #3 after the fall and she revealed she had not looked at the POC device prior to providing care to Resident #9. She reported she also spoke with Nurse #5 and re-educated her on the facility ' s normal procedure for the nurses to assign and distribute the POC devices to the NAs within the first hour of their shift. The DON stated she expected NAs to review the POC device prior to caring for a resident, to provide care according to resident ' s assessed needs, and for the nurses to assign and distribute the POC devices according to the facility ' s normal procedure.

2. Resident #39 was admitted to the facility on 3/16/18 and last readmitted on 5/4/18 following a hospitalization for a fracture of the left femur. Additional diagnoses included history of falling, anxiety and depression. Resident # 51 also sustained a fall on 7/3/18 resulting in a fracture of the facial bones.

An admission Minimum Data Set (MDS) dated 4/14/18 indicated Resident #39 was cognitively intact. He required extensive assistance with bed mobility, transfers, toileting and personal hygiene. Ambulation did not occur. Resident #39 ' s balance was impaired with surface to surface transfers and he was only able to stabilize with human assistance. The MDS noted Resident #39 had sustained one fall with no injury since the last assessment.

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A review of incident/ accident reports for Resident #39 revealed the following:
An incident report dated 3/26/18 at 6:19 AM stated Resident #39 was found on the floor. He was trying to transfer from his chair to the bed and was sitting on the floor. He was wearing nonskid footwear, call light was within the reach of the resident and the area/floor was clean and dry. Resident #39 was last toileted at 3:40 AM. Resident #39 required an assistive device of a wheelchair. The wheelchair was locked. Interventions going to be put into place-- educated resident on ambulating and transferring without assistance, use call bell when he needs help. Incident report stated Resident was trying to get into bed out of chair. Chair was locked and he slipped out into floor. No injury was noted. Additional follow ups: 3/27/18 resident had an unwitnessed fall. Resident was attempting to self-transfer from chair to bed. Nurse observed resident sitting in the floor on buttocks in front of chair. Resident stated he slid out of his chair. A non-slip mat was placed in resident's wheelchair.

An incident report dated 4/13/18 at 9:10 AM stated Resident #39 was found on the floor. He was trying to dress himself without assistance and was on his buttocks beside the closet. He was facing the door. He was noted to be incontinent at the time of the fall. Interventions put into place: Education for call light use, nonskid footwear. Resident reported that he was trying to dress himself. Found on floor on buttocks. No injuries observed. Denies pain. Denies hitting hard.

A care plan dated 4/13/18 stated Resident #39 had potential for fall related injury. He required assistance with ambulation, bed mobility and

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transfers. He had an unwitnessed fall on 4/13/18. Interventions included, in part, encourage use of nonskid footwear. Encourage resident to notify staff with need of assistance for transfers and/or ambulation. Further interventions dated 4/18/18 included: keep bed in low position. Keep call light in reach. Keep clutter free path to bathroom. Position rolling walker close to bed and within resident ' s reach.

An incident report dated 4/26/18 stated Resident #39 reported a fall to the nurse. Resident #39 reported to nursing staff that he had a fall when attempting to pull back his sheets and get into bed. No injuries were noted. Antirollbacks (device added to a wheelchair to prevent the wheelchair from rolling backwards) were already applied to resident's wheelchair. Interventions going to be put into place: antirollbacks applied to wheelchair already. Resident #39 was encouraged to use his call light.

Intervention of antirollbacks applied to the wheelchair was added to the care plan on 4/26/18.

An incident report dated 5/1/18 at 12 noon stated Resident #39 was found on the floor sitting on bottom by therapy; He said he transferred by himself to get something out of the drawer. Skin tear noted on elbow. Immediate action taken: dry bandage, neurological checks, transfer to hospital. Physician and family notified on 5/1/18 at 12:15 PM. The incident follow up note said Resident #39 was hospitalized with a fracture of the left femur.

The intervention of application of an anti-slip pad to be added to the wheelchair was added to the

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care plan dated 5/1/18.

An incident report dated 5/7/18 at 7:10 PM stated Resident #39 was found sitting upright with his back to the wheelchair. No injury noted. The Post Huddle form dated 5/7/18 indicated Resident #39 had an alarm device in place and the alarm was functioning properly. Interventions going to be put into place: safety reminders provided and resident removed from room after toileting. Follow up report dated 5/2/18 stated Resident #39 had an unwitnessed fall. Resident stated he was attempting to self- transfer form wheelchair to the toilet because he didn't think he needed help. Nurse observed resident sitting in the floor in his restroom with his back to the wheelchair facing the doorway. Medications were reviewed by his physician. A pad alarm was to be on his wheelchair always. Hipsters (undergarment with padding on each hip to protect the hip in event of a fall) was fitted to resident and were being worn.

The intervention added to the care plan on 5/7/18 included the use of fitted hipsters to be given to and worn by resident.

An incident report on 5/14/18 at 5:40 AM said Resident #39 was trying to toilet himself. He was sitting on his buttocks with legs extended forward. He did not hit his head. Interventions: continue with bed/ chair alarm. No injury sustained. Staff were unable to reach resident in time to prevent him from sliding down doorway. No injury was sustained. No noted loss of skin integrity. Additional follow up notes dated 5/15/18 stated Resident #39 was relocated to a room closer to the nurse ' s station for increased observation and he was placed on the toileting program (resident is offered/ taken to the bathroom before

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and after meals and on rising in the morning and at bedtime).

Interventions added to the care plan dated 5/14/18 included, in part, toileting program (toilet upon rising, before and after meals, and at bedtime). Resident #39 was relocated to a room closer to the nurse ' s station for increased observation.

An incident report dated 7/3/18 at 7:47 PM stated Resident #39 was trying to transfer and lost balance and fell. He was sitting on the bedroom floor facing the window. The section for alarms being in place was blank. Resident sustained a skin tear to the left arm. In house treatment was done. 24 hour follow up stated Resident #39 sustained a skin tear to his left arm. X-ray from hospital revealed facial fracture. Additional follow-up notes dated 7/4/18 stated Resident #39 attempted to self-transfer from his wheelchair to the bed. Resident stated he did not know what he was doing and he lost my balance. Skin tear to left arm. standing orders initiated. X-ray showed facial fracture at hospital. Clip (personal) alarm applied to remind Resident #39 to request assistance. Resident encouraged to spend time at the nurse's station for increased nursing observation and diversional activity. Assist resident to bed earlier if tired and wanting to go to bed (offer earlier bed time).

On 7/11/18 at 3:27 PM, an interview was conducted with NA #10 regarding the fall that occurred on 7/3/18. She said she was walking down the hall and heard the pad alarm go off. She went to see what Resident #39 was doing and she was in between the beds when Resident #39 stood up and fell sustaining a skin tear on his

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arm, a tiny bruise on his left cheek and a red line on the back of his neck on the left side. He stood up and fell before she could tell him to wait.

Interventions added to the care plan included the use of a clip alarm to be used at all times.

A fall assessment dated 7/6/18 for Resident #39 revealed a score of 12. A score of 7-18 is a high risk for falls.

On 7/9/18 at 12:30 PM, Resident #39 was observed lying in bed. Antirollbacks were observed on his wheelchair. He had a bed mat alarm monitor in place. The clip alarm was not observed.

On 7/09/18 at 3:56 PM, an interview was conducted with Resident #39. He said he had a mat alarm in the bed that "tells on him" when he tries to get out of bed unassisted.

On 7/10/18 at 4:15 PM, an observation of Resident #39 was conducted. Resident 339 was lying in bed. A clip alarm was attached to his pajama top. The anti-slip mat was in his wheelchair on top of a wheelchair cushion and pad. Resident #39 was wearing an incontinent brief. He stated he did not have the hipsters on at that time.

On 7/10/18 at 4:15 PM, an interview was conducted with NA #10. She said she provided care for Resident #39 on the evening shift (3:00PM--11:00PM) and had worked at the facility about two weeks. When asked about fall interventions used for Resident #39, she stated they used a gait belt for transfers, he had antirollbacks on his wheelchair and they had put a

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personal alarm on Resident #39 today. She was unaware that Resident #39 should have an anti-slip mat in his wheelchair or that he should have hipsters on. She stated she had not been told about Resident #39's need to wear the hipsters. NA #10 stated the nursing assistants had an electronic hand-held care guide they used to find out what was needed to provide care for the resident.

On 7/10/18 at 5:10 PM, an interview was conducted with the Unit Manager who stated Resident #39 had the pad alarm that had been changed to a clip alarm 7/10/18, an anti-slip mat in his wheelchair, antirollbacks to the wheelchair. She stated Resident #39 was to wear hipsters always and had been placed on a toileting program to offer toileting and assist him to the bathroom before and after meals and at bedtime. The Unit Manager stated the nursing assistants documented their care in the electronic care guide and there was a nursing assistant book at each nursing station that the nursing assistants should look at the beginning of their shift to find out what care should be provided for the resident. The Unit Manager checked the nursing assistant book for the information provided for Resident #39 and noted the care guide only mentioned antirollbacks to wheelchair and the anti-slip mat for the wheelchair.

On 7/10/18 at 5:10 PM, an observation of Resident #39 was conducted with the Unit Manager. Resident #39 did not have hipsters on. The anti-slip mat was observed on top of the cushion and pad. She stated Resident #39 should have had hipsters on and the anti-slip mat should have been under the cushion and applied on the seat of the wheelchair.

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F 689	Continued From page 47 On 7/10/18 at 5:15 PM, an interview was conducted with the RN Clinical Specialist. She checked the electronic device used by the nursing assistants and noted the only item mentioned on the electronic device was the use of incontinent briefs. She also reviewed the nursing assistant book and stated the Staff Development Coordinator updated the care guide at least once a week or more frequently if needed. Also, any nurse could update the nursing assistant care guide. On 7/11/18 at 9:52 AM, an interview was conducted with the Director of Nursing who stated she expected fall interventions to be updated, accurate in the nursing assistant book and all interventions should be in place and used. On 7/11/18 at 10:06 AM, an interview was conducted with the Staff Development Coordinator who stated she updated the nursing assistant book monthly and when new fall interventions were added. She said she was the only one who kept the resident information updated. The Staff Development Coordinator stated the use of the hipsters was not noted in the nursing assistant book because that was not a fall intervention. They were used to protect resident #39 from injury should he fall again. She stated the use of the personal clip alarm should have been put in the nursing assistant book	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who	F 695		7/31/18

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F 695	Continued From page 48 needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, resident and staff interview, the facility failed to obtain a physician ' s order for respiratory care for a resident with chronic respiratory failure. This was for one of one residents reviewed for respiratory care (Resident #212). The findings included: Resident #212 was admitted to the facility 7/5/18. Cumulative diagnoses included, in part, chronic respiratory failure, chronic obstructive pulmonary disease (COPD) and acute and chronic respiratory failure with hypercapnia (abnormally elevated carbon dioxide (CO2) levels in the blood). No Minimum Data Set (MDS) data was available or completed at the time of the survey. A nursing admission note dated 7/5/18 at 3:20 PM stated Resident #212 was admitted with the following diagnoses that included COPD and chronic respiratory failure. Resident #212 was alert, verbal and oriented to time, place and situation. Respirations were even and non-labored without any cough noted. She was on oxygen therapy via nasal cannula at one (1) liter/ minute. A daily skilled nursing note dated 7/6/18 at 5:01 PM indicated Resident #212 was on oxygen at 1	F 695	Resident #212 admitted to the facility on 7/5/2018, at time of admission she was using oxygen. Resident #212 stated she used oxygen at home and nurses continued to administer oxygen per resident #212 request. The admitting nurse did not enter an order for the oxygen. On 7/10/2018, when the Unit Manager was made aware that resident #212 did not have an order for oxygen, an order was requested from the Nurse Practitioner and obtained. On 7/10/2018 an oxygen order was entered for resident #212 to have oxygen at a rate of 3.0 liters per minute (L/min) by the Unit Manager. An audit was completed by the Unit Manager to ensure residents have an MD order for oxygen use, all orders were deemed accurate on 7/24/2018. The facility created a new QA team, The 2018 Annual Survey Plan of Correction QA Team, to implement the plan of correction. The Electronic Medical Record (EMR) system was adjusted, a notation was added in the EMR software under the resident admission assessment to ensure the resident has a Medical Doctor order for oxygen. The Clinical	

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F 695	Continued From page 49 liter/minute via nasal cannula. On 7/09/18 at 12:06 PM, Resident #212 was observed lying in bed. She was receiving oxygen via nasal cannula. The oxygen concentrator was noted to be delivering one (1) liter of oxygen. Minute. Resident #212 stated she was on oxygen therapy at home but she was on more than 1 liter/ minute. On 7/10/18 at 2:47 PM, a second observation was conducted and revealed the oxygen concentrator was set on 3 liters/ minute. Resident #212 said nursing staff changed the amount she received sometime between 7/9/18 and 7/10/18. She was unsure who/when exactly it was changed. Resident #212 said she was on 3 liters of oxygen at home and sometimes 3.5 liters. Resident denied that she had any shortness of breath or any breathing problems since admission. A review of physician orders for Resident #212 revealed no physician orders for oxygen therapy. A review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed no documentation regarding the use of oxygen therapy. On 7/10/18 at 5:10 PM, an interview was conducted with the Unit Manager who stated a physician order should be written if a resident was on oxygen therapy. She stated the admitting nurse would write the order if oxygen was noted on the discharge summary. If a resident was on oxygen and the order was not on the discharge summary, the nurse should call the physician and obtain an order for oxygen. The Unit Manager	F 695	Specialist, who has the ability to make changes within the EMR system, made the necessary oxygen related notation in the system on 7/24/2018. All nurses (which includes full time, part time, and PRN) were in-serviced to ensure residents receiving oxygen have a physicians order by the Director of Nurses by 7/31/2018; nurses not in-serviced prior to 7/31/2018 will be in-serviced at the beginning of his/her next scheduled shift. A monitoring tool, the “Oxygen MD Order Audit” was created to ensure residents receiving oxygen, have a current MD order. The monitoring tool will be completed by the Unit Manager, weekly on all residents for 6 months. The Unit Manager will bring completed Oxygen MD Order Audits to the weekly QI meetings; the monitoring tool will be reviewed weekly for 3 months then monthly thereafter. The Director of Nurses and interdisciplinary team will be responsible for noting any order omissions as related to residents receiving oxygen. The Director of Nurses will be responsible for reporting the QA team’s efforts at the Executive Quarterly QA meetings. The next scheduled Executive Quarterly QA meeting is scheduled for 7/31/2018. The Director of Nurses will be responsible for ensuring compliance with this plan of correction. The facility alleges compliance with all aspects of this portion of the plan of correction by 7/31/2018.	

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F 695	Continued From page 50 said there were also standing orders for oxygen for acute situations and a physician order would be written also. She reviewed the physician orders for resident #212 and said there were no orders for oxygen use. She said a physician order should have been written. On 7/11/18 at 9:56 AM, an interview was conducted with the Director of Nursing who stated she expected a physician's order to be written if a resident was on oxygen.	F 695		
F 730 SS=F	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide training that addressed needs and care of residents with dementia to 5 of 5 nurse aides (NAs) reviewed (NA #5, #6, #7, #8, & #9). Findings included: NA #5 was assigned to the dementia care unit. Review of her in-service records revealed that she was not trained on how to care for residents with dementia. NA #6 was assigned to the dementia care unit. Review of her in-service records revealed that she was not trained on how to care for residents with dementia.	F 730	Dementia care training was previously provided by the Ombudsman. The Ombudsman provided annual training in 2017, but provided training on a different topic than the routine dementia care and Resident's Rights training. Dementia care training was previously scheduled to occur in July 2018. Training will occur as scheduled on July 30-31, 2018 by the consultant Pharmacist. The consultant Pharmacist has provided dementia care training to staff previously; she is dementia care certified. For those staff who are unable to attend the July	7/31/18

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F 730	Continued From page 51 NA #7 was assigned to the dementia care unit. Review of her in-service records revealed that she was not trained on how to care for residents with dementia. NA #8 was assigned to the dementia care unit. Review of her in-service records revealed that she was not trained on how to care for residents with dementia. NA #9 was assigned to the dementia care unit. Review of her in-service records revealed that she was not trained on how to care for residents with dementia. On 7/12/18 at 10:05 AM, the Staff Development Coordinator (SDC) was interviewed. The SDC verified that the staff did not have dementia care training. She indicated that she had requested the pharmacist to provide the dementia training but there was no date yet as to when the training would be conducted. On 7/12/17 at 12:29 PM, the Director of Nursing (DON) was interviewed. She verified that there had been no dementia training provided to the staff in the past but the pharmacist would be scheduling the training in August.	F 730	30-31 dates, dementia care training will be provided to all staff (which includes full time, part time, and PRN ("as needed") staff) at the beginning of his/her next scheduled shift. Additionally, dementia care training videos have been purchased and are expected to arrive at the facility on August 6, 2018. Dementia training, whether by video or a compliance test will be provided to all new hires beginning August 1, 2018. The facility is also pursuing online in-service training, which will include dementia care training for staff, with an implementation goal of January 1, 2019. The online in-service system will track employee participation with training to ensure modules are completed timely. Until online in-services begin the Staffing Coordinator will continue to monitor and record attendance with required in-service training. The Administrator will be responsible for discussing staff training needs at the Executive Quarterly QA meetings. The next scheduled Executive Quarterly QA meeting is scheduled for 7/31/2018. The Administrator will be responsible for ensuring compliance with this plan of correction. The facility alleges compliance with all aspects of this portion of the plan of correction by 7/31/2018.	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F 755		7/31/18

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F 755	Continued From page 52 §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to discard expired medications and failed to date multi dose medications in 1 of 4 medication carts observed (Medication cart B). Findings included:	F 755	Nurses failed to adequately inspect medication carts for expired and undated items. Undated and expired items were discarded once noted.	

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F 755	Continued From page 53 The manufacturer's specifications for Levemir (long acting insulin used to treat high blood sugar) and Latanosprost (used to treat glaucoma) were reviewed. The specifications indicated that Levemir and Latanosprost were good for 42 days after opening. On 7/12/18 at 10:25 AM, medication cart B was observed with the Staff Development Coordinator (SDC). The following were observed: 1. Used Levemir pen with an open date of 5/14/18. 2. Used Latanosprost eye drops with no open date. The dispensed date was 5/26/18 3. Used Polymyxin (used to treat bacterial infection of the eye) eye drops (2 bottles) with no open date. The dispensed dates were 2/15/18 and 6/30/18. On 7/12/18 at 10:30 AM, the SDC was interviewed. She observed the used Levemir pen and verified that it was expired and stated that it should have been discarded 42 days after opening. The SDC further stated that the eye drops should have been dated when opened. She also verified that the used Latanosprost eye drops was not dated and should have been discarded 42 days after opening. The SDC indicated that the facility policy on Polymyxin eye drops was to discard the medication after the end of treatment. She indicated that the treatment ended on 7/2/18 and the medications should have been discarded.	F 755	On 7/16/18, a pharmacy staff member came to the facility to inspect all medication carts for expired medications and open dates. The pharmacy representative noted a few out of date and undated items on her report; each individual finding was addressed with the nurse responsible for the cart or medication room. All full time, part time, and PRN (“as needed”) nurses, were in-serviced by the Director of Nurses to ensure medication items are dated and within the manufacturer’s expiration date by 7/31/2018; nurses who have not received the in-service by 7/31/2018 will be in-serviced at the beginning of his/her next scheduled shift. The facility created a new QA team, The 2018 Annual Survey Plan of Correction QA Team, to implement the plan of correction. The updated process/procedure for monitoring unlabeled or out of date items cited was in-serviced to Nurses by the DON by 7/31/2018. A monitoring tool, “Night Nurse Duties” was created to ensure compliance with dating eye drops and insulin and ensuring no expired items are left in the medication carts. The monitoring tool will be completed on all carts for one calendar year. Medication carts will be checked daily by the night shift nurse, at least monthly by a pharmacy representative and Administrative Nurses to ensure no undated or expired items are stored within the medication carts. Administrative nurses and the pharmacy representative will report any findings of undated or out	

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F 755	Continued From page 54 On 7/12/18 at 12:29 PM, the Director of Nursing (DON) was interviewed. She stated that she expected the nurses to date multi dose medications and to discard expired medication. The DON stated that the pharmacy checked the carts monthly and the nurses were supposed to check the carts daily.	F 755	of date items to the Director of Nurses. The Director of Nurses will bring completed Night Nurse Duties sheets to the weekly QI meetings; the monitoring tool will be reviewed weekly for 3 months then monthly thereafter. The Director of Nurses and interdisciplinary team will be responsible for noting any issues with undated or expired items and making adjustments to ensure facility expectations are met and in line with regulatory compliance. The Director of Nurses will be responsible for reporting the QA team's efforts at the Executive Quarterly QA meetings. The next scheduled Executive Quarterly QA meeting is scheduled for 7/31/2018. The Director of Nurses will be responsible for ensuring compliance with this plan of correction. The facility alleges compliance with all aspects of this portion of the plan of correction by 7/31/2018.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic	F 758		7/31/18

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F 758	Continued From page 55 Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observations, staff and Consultant	F 758	The physician failed to give a specific	

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F 758	Continued From page 56 Pharmacist interviews and record review, the facility failed to ensure an as needed (PRN) antianxiety medication was time limited in duration for 1 (Resident #106) of 5 residents reviewed for unnecessary medications. The findings included: Resident #106 was admitted on 3/9/17 with cumulative diagnoses of Dementia with behavioral disturbances, Anxiety, Insomnia and Depression. Resident #106's quarterly Minimum Data Set dated 6/13/18 indicated severe cognitive impairment and she was coded as exhibiting hallucinations, delusions, physical, verbal and other behaviors. Resident #106 was care planned for the use of psychotropic medications last revised 6/22/18. The care plan indicated she was to receive her medications as ordered. Review of Resident #106's July 2018 physician orders included an order dated 2/19/18 for Valium (antianxiety medication) 5 milligrams (mg) I tablet by mouth two times per day as needed for anxiety. Review of Resident #106's Medication Administration Records (MARs) from February 2018 to July 2018 indicated the following: February 2018 MAR: received PRN Valium on 1 occasion March 2018 MAR: received PRN Valium on 7 occasions April 2018 MAR: received PRN Valium on 14 occasions May 2018 MAR: received PRN Valium on 13	F 758	stop date for PRN (an abbreviation for the Latin term, "pro re nata" which loosely translates to "as needed") Valium as ordered for resident #106. In a progress note dated 5/31/2018, the physician met the requirements of “document their rationale in the resident’s medical record and indicated the duration,” but failed to include the specific duration in the PRN order. The physician provided an updated order on 7/17/18 for the PRN medication which reads: “to be continued until 7/31/18, re-evaluated by Dr. Subbiah for continuation at that time.” The Clinical Specialist reviewed all other PRN psychotropic medication orders in LG (Life’s Good) and noted there was only one other resident with a PRN psychotropic medication order. This resident’s order was deemed correct with a duration and specific stop date noted for the PRN medication order. The Clinical Specialist will continue to pull a group report for PRN psychotropic medications weekly. Using the EMR system, the facility has parameters set up that any PRN psychotropic medication automatically has a 14 day duration entered into the order. Nurses have been educated that all PRN medication requires a stop date to be written in the physician’s order. The stop date will not be permitted to be changed without physician re-evaluation and approval. The facility will use the EMR system and the consultant Pharmacist	

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F 758	Continued From page 57 occasions June 2018 MAR: received PRN Valium on 15 occasions July 2018 MAR: received PRN Valium on 6 occasions as of 7/6/18 Review of a Pharmacy Consultant Communication form dated 3/3/18 read the PRN Valium should be time limited to 14 days. The form read the Physician needed to document rationale and indicated the duration of the PRN order. The form was signed by the Physician and dated 3/6/18. The Physician did not indicate agreement or modify his order dated 2/19/18. Review of Psychiatric Progress note dated 4/24/18 indicated Resident #106 continued to experience hallucinations, delusion and behaviors. The progress note did not mention the RPN Valium originally ordered 2/19/18. Review of a Pharmacy Consultant Communication form dated 6/1/18 read the PRN Valium should be time limited to 14 days. The form read the Physician needed to document rationale and indicated the duration of the PRN order. The form was signed by the Physician and undated. The Physician documented "see monthly note." Review of a Physician Progress Note dated 5/31/18 read: Previous attempts to reduce the PRN Valium have failed. Will continue the PRN Valium and re-evaluate in 60 days. Review of Resident #106's nursing notes from February 1st, 2018 to July 8th, 2018 revealed episodes of screaming at staff, yelling at staff and delusions.	F 758	reports to monitor compliance with this regulation. The Director of Nurses completed in-service training by 7/31/18 for all full time and part time nurses. All PRN staff members were in-serviced with the LG communication module to ensure all staff were in-serviced prior to the start of his/her next scheduled shift. The Clinical Specialist or consultant Pharmacist will report findings and corrective actions of any PRN psychotropic medication without a stop date or duration for six months at the Executive QA meetings. The next Executive QA meeting is scheduled July 31, 2018. The Clinical Specialist will be responsible for ensuring compliance with this plan of correction. The facility alleges compliance with all aspects of this portion of the plan of correction by 7/31/2018.	

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During an observation on 7/10/18 at 5:30 PM, Resident #106 appeared awake and pleasant. She was absent of behaviors, visual or auditory hallucinations.

During an observation on 7/11/18 at 7:50 AM, Nursing Assistant (NA #2) was assisting Resident #106 with her breakfast. Resident #106 appeared awake and cooperative.

Interview on 7/11/18 at 11:40 AM, NA #2 stated Resident #106 was cooperative today with her care. She stated Resident #106's behavioral status could change rapidly. NA #2 stated Resident #106 often screamed and cursed at the staff. She stated Resident #106 was not able to be calmed or redirected and often staff had to sit with her or a family member would come to calm her down.

In a telephone interview on 7/11/18 at 3:41 PM, the Consultant Pharmacist recalled completing the Pharmacy Consultant Communication forms dated 3/3/18 and 6/1/18 on Resident #106. She stated she was aware of the 14-day limited use of PRN psychotropic in the absence of a physician re-assessment, rationale and stated duration for continuation. The Consultant Pharmacist stated she was just at the facility the previous day and did not read the Physician progress note dated 5/31/18 where he recommended the continuation of the PRN Valium for another 60 days. She stated a new order should have been written on 5/31/18 to continue the PRN Valium for 60 days because the electronic Medication Administration Record (MAR) still read 2/19/18 as the order date with no stop date for 60 days from 5/31/18. The Consultant Pharmacist stated the facility would

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F 758	Continued From page 59	F 758		

not know the PRN Valium was time limited in duration without a physician order.

In an interview on 7/12 at 8:30 AM, Nurse #1 stated she frequently had to administer Resident #106's PRN Valium. She stated Resident #106 was not easy to re-direct or calm and the facility has had to call her family to come and assist with her behaviors.

In an interview on 7/12/18 at 9:21 AM, the Nurse Practitioner (NP) stated when she or the Physician received the Pharmacy Consultant Communication forms, they respond to any recommendations and returned the forms to the Unit Manager to write any new orders. She stated it was her expectation that there was a written order on 5/31/18 to continue the PRN Valium for 60 days. The NP stated the prescribing Physician was out of town and unable for telephone interview.

In an interview on 7/12/18 at 10:07 AM, the Unit Manager stated she reviewed the Pharmacy Consultant Communication forms after the NP or Physician responses to the recommendations. She stated she did not realize a new written order was needed to continue the PRN Valium for 60 days from 5/31/18. She stated the electronic MAR still indicated the PRN Valium was initially ordered 2/19/18 with no stop date.

In an interview on 7/12/18 at 12:26 PM, the Director of Nursing (DON) stated she was aware of the 14-day time limited duration of PRN psychotropic medications. She stated the original order dated 2/19/18 should have been addressed by the NP or Physician when the first Pharmacy Consultant Communication form was completed

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F 758	Continued From page 60 on 3/3/18. The DON stated it was her understanding that as long as the Physician documented the rationale and time limit of 60 days for the continued use of Resident #106's PRN Valium, there was no need for a new physician order. She stated it was her view that the Consultant Pharmacist who visited monthly would have seen the Physician Progress Note dated 5/31/18 and followed up with the physician after 60 days. The DON stated the electronic MAR from which the nurses administered the PRN Valium read the order date of 2/19/18 with no stop date and the nurses would not know that 60 days after 5/31/18 they could not administer the PRN Valium.	F 758		
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	F 812		7/31/18

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F 812	Continued From page 61 by: Based on observations and staff interviews, the facility failed to prepare food under sanitary conditions, discard expired food in 2 of 3 refrigerators, and failed to store food at proper temperatures in 2 of 3 nourishment refrigerators. The findings included: During the initial tour of the facility kitchen on 7/9/18 at 10:08 AM the Executive Chief (EC) was observed sautéing vegetables on the grill top. It was noted that the EC had a beard (facial hair) and not wearing a beard guard. During observation of refrigerator #2, there were 2 cartons of 2% milk dated 7/3/18 as the expiration date. Observed in refrigerator #1 were 3 cartons of Lactaid (Lactulose-free milk) dated 6/19/18 as the expiration date. The EC stated the expired items should have been discarded at the time of expiration. Observation was conducted on 7/11/18 at 10:11 AM on Ashley Hall. The Nourishment refrigerator temperature was 48 degrees. On Memory Lane Unit, the nourishment refrigerator was observed at 50 degrees. The contents of both refrigerators included milk, juice, supplements and left over resident food. During a second observation on 7/11/18 at 11:45 AM, the EC was observed cooking of the grill top again not wearing a beard guard. On interview, he stated he told if his beard measured 1 inch or less, he did not need to wear a beard guard. The	F 812	Expired milks were noted in 2 of 3 refrigerators as dietary staff did not thoroughly inspect refrigerators for expired items. The facility policy regarding hair restraints did not specify that beard restraints are required, but rather that hair restraints should be utilized to prevent hair contact with food, work surfaces, or utensils. Nourishment refrigerator #1 was found to be holding temperature adequately following the survey; nourishment refrigerator #2 was found to be in need of de-thawing. Expired milk containers were discarded immediately during rounds with the surveyor. The Executive Chef and Administrator made rounds during the survey on 7/11/2018 and found no more outdated items. The policy regarding hair restraints was updated on 7/25/2018 by the Administrator to include beard restraints; beard guards must be worn for all facial hair to prevent exposure. Nourishment refrigerator #1 was checked again and is adequately maintaining temperature. Nourishment refrigerator #2 was de-thawed on 7/25/2018 by the housekeeping Assistant Supervisor, contents discarded and the refrigerator is now adequately maintaining approved temperature. The facility created a new QA team, The 2018 Dietary Plan of Correction QA Team, to implement the plan of correction. The updated process and policy for monitoring expired items, utilizing beard restraints	

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F 812	Continued From page 62 EC confirmed he had beard guards readily available. The EC stated the temperature in the nourishment room refrigerators should be maintained at 41 degrees of less. In an interview on 7/11/18 at 12:20 PM, the Administrator stated it was his expectation that dietary staff hair be covered during meal preparation and serving but he did not think the EC's beard required a beard guard due to the length. He also stated expired milk products should have been discarded upon expiration and food should be stored at the proper temperatures.	F 812	(updated "Dietary Employee Hygiene Policy"), and ensuring refrigerators are at acceptable temperatures was in-serviced to Dietary Staff by the Executive Chef by 7/31/2018. A monitoring tool, "Kitchen Sanitation Rounds" was created to ensure compliance with expired items, proper employee attire, and appropriate refrigerator temperatures. The monitoring tool will be completed for one calendar year. The kitchen and food storage areas will be checked daily by the Executive Chef or Cook Supervisor for expired items and appropriate refrigerator temperatures; the Executive Chef or Cook Supervisor or will also ensure compliance with the revised employee attire policy. The Executive Chef and Administrator will make weekly rounds, utilizing the above mentioned monitoring tool, for three months and at least monthly thereafter to ensure regulatory compliance. The Executive Chef will be responsible for reporting the QA team's efforts at the Executive Quarterly QA meetings. The next scheduled Executive Quarterly QA meeting is scheduled for 7/31/2018. The Executive Chef will be responsible for ensuring compliance with the above mentioned plan of correction elements. The facility alleges compliance with all aspects of this portion of the plan of correction by 7/31/2018.	
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i)	F 865		7/31/18

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F 865	Continued From page 63 §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident interview, and staff interview, the facility ' s Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place following the 8/31/16 and 8/3/17 recertification surveys in the areas of Accuracy of Assessments (483.20) and Food Safety Requirements (483.60), following the 8/3/17 recertification survey in the area of Care Plan Timing and Revisions (483.21), and following the 10/26/17 complaint investigation survey in the area of Accident Hazards (483.25). These 4 deficiencies were cited again on the current recertification survey of 7/12/18. The continued failure of the facility during 2 or more federal surveys of record show a pattern of the facility ' s inability to sustain an effective Quality Assessment and Assurance program. The	F 865	This deficiency, which is due to repeated issues in other areas, was analyzed and determined that due to human error, staff knowledge deficit(s), and failure to follow facility expectations, regulatory non-compliance was present. The facility submitted plans of correction in 2017 which was accepted and had been followed. QA efforts referenced at that time were successful in reducing the severity of deficiencies, though deficient practice was noted during the annual recertification survey. The expansion of the MDS assessment areas audited, kitchen monitoring, communication with care plan revisions, and ensuring POCS devices are available and fall interventions being posted in real time were determined to be necessary to prevent future	

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F 865	Continued From page 64 findings included: This tag is cross referenced to: 1. 483.20 Accuracy of Assessments: Based on record review, observation, resident interview, and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of physical restraints (Resident #56), behaviors (Resident #64), falls (#24), and dental (#262) for 4 of 23 residents reviewed. During the recertification survey of 8/31/16 the facility was cited at 483.20 Accuracy of Assessments for failing to code the MDS assessment accurately in the area of Preadmission Screening and Resident Review level II. During the recertification survey of 8/3/17 the facility was cited at 483.20 Accuracy of Assessments for failing to code the MDS Assessment accurately in the areas of physical restraints and vision. On the current recertification survey of 7/12/18 the facility was cited for failure to code the MDS assessment accurately in the areas of physical restraints, behaviors, falls, and dental. 2. 483.60 Food Safety Requirements: Based on observations and staff interviews, the facility failed to prepare food under sanitary conditions, discard expired food in 2 of 3 refrigerators, and failed to store food at proper temperatures in 2 of 3 nourishment refrigerators. During the recertification survey of 8/31/16 the facility was cited at 483.60 Food Safety Requirements for failing to maintain clean and/or in good repair kitchen floors, stove, oven, and nourishment refrigerators as well as failing to	F 865	deficiencies in these area. The facility has modified the internal QA process/audit of: the MDS assessment accuracy, food safety requirements, care plan timing and revisions, and accident hazards to allow for regulatory compliance with the specific deficiency noted. The facility will update the QAPI plan and updated the Facility Assessment, no later than October 31, 2018. During updates of the QAPI plan and the Facility Assessment, Administration will look for other potentially deficient practice(s), necessary staff training requirements, and solutions to noted areas of potential regulatory non-compliance. To monitor for plan of correction effectiveness and compliance, the facility created the 2018 Annual Survey Plan of Correction QA team, which will monitor this plan of correction. The 2018 Annual Survey Plan of Correction QA Team will next meet on 8/3/2018. The QA Team created QA monitoring tools (MDS Assessment Accuracy Tracking Log, Kitchen Sanitation Rounds tool, Care Plan Accuracy Tracking Log, and POCs device and fall intervention updates) which will allow the appropriate staff to verify the accuracy with regulatory requirements. The summary results of the above mentioned Tool/Logs will be presented to the 2018 Annual Survey Plan of Correction QA team at least monthly and will continue through the next survey process at a minimum. These results (with QAPI analysis format) will also be	

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F 865	Continued From page 65 label and date stored food items and discard expired foods. During the recertification survey of 8/3/17 the facility was cited at 483.60 Food Safety Requirements for failing to date thickened juices when opened. On the current recertification survey of 7/12/18 the facility was cited for failure to prepare food under sanitary conditions, discard expired foods, and store food at proper temperatures. 3. 483.21 Care Plan Timing and Revisions: Based on record review, observation, resident interview, and staff interview, the facility failed to review and revise plans of care related to an abdominal binder (Resident #56), dialysis (Resident #24), and contractures (Resident #51) for 3 of 23 residents reviewed. During the recertification survey of 8/3/17 the facility was cited at 483.21 Care Plan Timing and Revisions for failing to revise care plans related to dialysis and vision. On the current recertification survey of 7/12/18 the facility was cited for failure to revise care plans related to an abdominal binder, dialysis, and contractures. 4. 483.25 Accident Hazards: Based on record review, observation, resident interview, and staff interview, the facility failed to prevent a resident from falling out of bed during a bed bath when one staff provided assistance for a resident who was dependent on two or more staff for bathing (Resident #9) and failed to implement fall interventions for a resident at high risk for falls (Resident #39). This was for 2 of 4 residents reviewed for accidents. During the complaint investigation survey of 10/26/17 the facility was cited at 483.25 Accident	F 865	reported will also be reported by the appropriate department leaders at the Executive Quarterly QA meeting. The next scheduled Executive Quarterly QA meeting is scheduled for 7/31/18. The Administrator will be responsible for ensuring compliance with the above mentioned plan of correction elements. The facility alleges compliance with all aspects of this portion of the plan of correction by 7/31/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345330	A. BUILDING _____ B. WING _____	07/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 865	Continued From page 66	F 865		

Hazards for failing to prevent injury for a resident at risk for injury related to a history of falls. On the current recertification survey of 7/12/18 the facility was cited for failure to prevent a resident from falling out of bed during a bed bath and failure to implement fall interventions.

An interview was conducted with the Administrator 7/12/18 at 12:35 PM. The Administrator indicated he was the head of the facility ' s QAA Committee. He indicated he was the Administrator during the previous recertification surveys of 8/31/16 and 8/3/17 and the complaint investigation survey of 10/26/17. He reported he was aware of the citations from these previous surveys. The Administrator indicated there had been changes in the MDS staff over the past year which could have contributed to the repeat citations in the areas of Accuracy of Assessments and Care Plan Timing and Revisions. He stated the facility currently had only 1 MDS Nurse and they were currently looking to hiring another MDS Nurse. He indicated he was not sure why there was a repeat citation in the area of Food Safety Requirements. He reported that in regard to the repeat citation for Accident/Hazards, the facility needed a monitoring process to ensure fall interventions were implemented.