STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	C 08/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	**820 KLUMAC ROAD SALISBURY, NC 28144**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS There were was one deficiency cited as a result of substantiating a complaint. The deficient practice was discovered during the recertification completed in conjunction with the complaint investigation survey of 8/30/18. Event ID#JXNQ11. 10/22/18 management decision to lower severity for F 584 to B BW	F 000		
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F 584		9/26/18

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

Electronically Signed | 09/24/2018

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F 584	Continued From page 1 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain a clean environment for five of five rooms (B-04-A, B-05-B, B-07-A, B-08-A, and B-14-A) reviewed for environment. Findings included: An observation conducted on 8/28/18 at 9:27 AM of room B-04 revealed a dust buildup on the exhaust vent in the bathroom. An observation conducted on 8/28/18 at 9:48 AM of room B-07 revealed a dust buildup on the exhaust vent in the bathroom. An interview was conducted with Resident #51 on 8/28/18 at 9:59 AM. The resident stated the housekeeper spent a brief amount of time in her room. The resident stated the housekeeper's cleaning routine included wiping off her over the bed table, emptying the trash, and putting a new liner in the trash can. An observation conducted on 8/28/18 at 11:49	F 584	Housekeepers failed to clean rooms properly due to lack of training and development. Rotating resident room deep cleaning schedule was temporarily on hold while facility relocated beds during remodeling. Rooms B4, B5, B7, B8, and B14 were cleaned by assigned housekeeper and inspected by Environmental Services Director on 8/31/18. Rotating room deep cleaning schedule was re-initiated by Environmental Services Director on 8/31/18. Environmental Services will deep clean 15 rooms a week starting 9/18/18. An inspection of room cleanliness will be done by Environmental Services Director or Senior Lead Housekeeper following each deep clean. The facility will maintain an ongoing schedule of at least 10 deep cleans per week.	

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F 584	Continued From page 2 AM of room B-05 revealed a dust buildup on the exhaust vent in the bathroom. An observation conducted on 8/28/18 at 12:05 PM of room B-08 revealed a dust buildup on the exhaust vent in the bathroom. Observations were made during room environment reviews of rooms conducted on 8/29/18 starting at 2:12 PM and ending at 2:31 PM. Rooms B-04-A, B-05-B, B-07-A, B-08-A, and B-14-A were discovered to have had an observed buildup of dust on the following: the bed frame of bed, the over the bed light, the sharps container in the bathroom, and the light over the sink in the bathroom. The dust buildup discovered in all rooms in the areas mentioned was found to be visible when wiped with a finger. A dust buildup was observed on the exhaust vent for the bathrooms in rooms B-04, B-05, B-07, and B-08. Room B-05-B had an observed tissue on the floor under the bed on the right side, a tissue next to the recline on the floor, and dust/dirt between the bedframe and the wall at the head of the bed. Room B-14-A had the following observed: dust on the floor under, next to, and beside the bed, a dead bug on the floor next to the bed, and straw wrappers on the floor in front of a recliner chair. An interview was conducted with Resident #51 on 8/30/18 at 10:37 AM. The resident stated the housekeeper had told her she had not felt well on 8/29/18. The resident stated the housekeeper had come in and swept a little, briefly mopped, and left. An observation of room B-14-A was conducted on 8/30/18 at 10:40 AM. The observation revealed	F 584	A complete audit of room cleanliness was conducted on all rooms by Environmental Services Director and Administrator on 9/3/18 and 9/4/18. All rooms that were found to be unclean were cleaned by assigned housekeeper and re-inspected by the Environmental Services Director on 9/3/18 and 9/4/18. All housekeeping staff will be in-serviced by Staff Development Coordinator and Environmental Services Director on proper cleaning and dusting of resident rooms procedures and proper deep clean procedures no later than 9/26/18 Environmental Services Director or Senior Lead Housekeeper will conduct cleanliness audits of 25 resident rooms a week for three months. Any unclean rooms will be cleaned by the assigned housekeeper by the end of their scheduled shift and re-checked by Environmental Services Director or Senior Lead Housekeeper. Audit results will be monitored at monthly Quality Assurance Performance Improvement (QAPI) meetings and any trends will be addressed by the Quality Assurance (QA) Committee. The Administrator is responsible for this Plan of Correction.	

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F 584	Continued From page 3	F 584		

the following: Tissue on the floor in front of the dresser, straw wrapper on the floor behind the recliner, a piece of paper on the floor behind the recliner, a dead bug on the floor next to the bed, dust/dirt/debris under the bed, dust buildup on the bed frame, dust buildup on the over the bed light, dust buildup on the sharps container in the bathroom, and dust build up on the light in the bathroom.

An interview was conducted with Housekeeper (HSK) #1 on 8/30/18 at 10:45 AM. The HSK stated there was a deep cleaning schedule for resident rooms. The HSK stated her usual routine when cleaning a resident room included: emptying the trash, wiping off the over the bed table, cleaning the bathroom, cleaning the toilet, restocking toilet paper, restocking the paper towels, sweeping the room, and mopping the room.

An observation conducted on 8/30/18 at 10:50 AM revealed dust on the exhaust vent in the bathroom of B-08.

An observation of room B-07-A was conducted on 8/30/18 at 10:51 AM. The observation revealed the following: Dust on the exhaust vent in the bathroom, dust buildup on the bed frame, dust/dirt/debris on the floor under the bed, and dust on the light in the bathroom.

An observation of room B-05-B was conducted on 8/30/18 at 10:54 AM. The observation revealed the following: dust buildup on the bed frame, dust on the exhaust vent in the bathroom, dust buildup on the over the bed light, dust/dirt/debris on the floor under the bed, and dust on the light in the bathroom.

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F 584	Continued From page 4	F 584		

An interview was conducted with the Director of Environmental Services Director (DES) in conjunction with a round of rooms B-04-A, B-05-B, B-07-A, B-08-A, and B-14-A on 8/30/18 at 11:00 AM. The DES stated there was not a deep cleaning schedule for resident rooms. The DES stated resident rooms were deep cleaned when they were vacated. The DES stated she had no record of rooms which had been deep cleaned. The DES observed dust build up on bed frames, over the bed lights, bathroom lights, and sharps containers located in resident bathrooms. The DES stated it was her expectation for there not to be a buildup of dust on resident furniture and other fixtures in resident rooms and bathrooms. The DES observed dust/dirt/debris/papers and a bug in resident room floors and stated her expectation was the floors of resident rooms should be thoroughly swept and mopped so there was not dust, debris, and other items on a resident floor. The DES observed dust on the bathroom exhaust vents in rooms B-04-A, B-05-B, B-07-A, and B-08-A. The DES stated it was her expectation for the housekeeping staff to dust the exhaust vent to prevent a dust buildup as part of the routine cleaning of a resident room.

An interview was conducted with the Administrator on 8/30/18 at 5:40 PM. The Administrator stated his expectation was for high dusting (dusting of light fixtures), sweeping/mopping around resident beds, dusting sharps containers, dusting of resident room furniture, and the dusting of the bathroom exhaust vents to be completed during general cleaning. In addition, the Administrator stated deep cleaning of resident rooms had been placed

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F 584	Continued From page 5 on hold but would resume immediately.	F 584		
F 641 SS=E	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, resident interviews and staff interviews, the facility failed to accurately code Minimum Data Sets (MDS) for 4 of 21 residents (Resident # 97, # 39 # 7 and # 107) reviewed for accuracy. Resident # 97 was admitted on 3/1/2018 to the facility with diagnoses that included major depressive disorder, anxiety disorder and chronic kidney disease, stage 3. A quarterly (MDS) assessment dated 8/16/2018 revealed Resident #97 had adequate hearing, clear speech, the ability to express ideas and wants, the ability to understand others and adequate vision. Resident # 97 was coded in Section C 0100 as rarely /never understood. Resident #97 was coded in Section D0500 A through J for no altered moods during the 14 day review period. Section E0800 for Resident # 97 was coded as no to rejection of evaluation or care. Section Q0100 revealed Resident # 97, family, significant other, guardian or legally authorized representative did not participate in the assessment. Section Q0550B indicated that source of information came from Resident # 97. A review of a care plan dated 3/2/2018 revealed Resident #97 had a potential to feel anxious,	F 641	Social Worker and Minimum Data Set (MDS) Coordinator failed to accurately code MDS assessments for resident #97, #7, #39, and #107 due to lack of training and development. MDS Coordinator was new to her position at the time of assessment completion. An MDS modification was completed for Resident #97□'s MDS assessment on 9/23/18, Resident #7'□s MDS assessment on 9/23/18, and Resident #39'□s MDS assessment on 9/23/18. All corrections were made by Staff Development Coordinator and Director of Nursing. A significant correction will be completed within 14 days for all modified assessments. Resident #107 is deceased therefore his assessment cannot be corrected. Social Workers was in-serviced on proper MDS coding, proper assessment and documentation of resident condition, including clinical documentation review by Staff Development Coordinator on 9/24/18. Additionally Social Workers will complete Relias Training Modules on MDS Sections C,D,E, and Q no later than	9/27/18

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F 641	Continued From page 6 scared, alone, depressed or sad related to anxiety disorder and depression. A review of a nurse's notes dated 8/15/2018 revealed Resident #97 had no sensory deficit limiting ability to feel or voice pain and discomfort and occasional refusal of meals. A review of a nurse's note dated 8/8/2018 revealed Resident #97 admitted to self-scratching that resulted in removal of dressing. A review of monthly psychiatric notes dated April 2018 through July 2018 revealed continued treatment for depression for Resident # 97. Further review of the psychiatric notes revealed Resident # 97 was still refusing recommended therapy. An interview with Resident # 97 revealed two spontaneous episodes of crying on 8/28/2018 at 3:46 PM. Resident # 97 disclosed she was taking Xanax (antianxiety medication) for her nerves. Resident # 97 further revealed she preferred to stay in her room to do arts and crafts and only moved to the facility in March 2018 after the death of her brother. An interview with the Social Worker (SW) on 8/30/2018 at 1:45 PM revealed it was her responsibility to complete sections C, D, E and Q of the MDS, complete triggered Care Assessment Areas (CAAs) and participate in care planning for Resident# 97. The SW revealed that she only attempted to interview Resident # 97 once during her review period. Additionally, the SW reported she did not review nurse's notes, physicians progress notes, psychiatric visit progress notes or any other medical record documents during the	F 641	9/27/18. Completion of Relias Training Modules will be confirmed by Staff Development Coordinator. Social Workers were provided a copy of the Resident Assessment Instrument (RAI)manual sections pertaining to Sections C,D,E, and Q. Social Workers will travel to sister facility for further hands-on training in resident assessment with their facility Social Worker on 10/2/18. MDS Coordinator was in-serviced on proper MDS coding, including Hospice coding and prognosis documentation review, by Staff Development Coordinator on 9/24/18. An audit of Sections C,D,E, and Q of all current resident's most recent MDS assessment was conducted by Staff Development Coordinator and Director of Nursing on 9/23/18 and 9/24/18 to ensure accuracy of assessments. The audit found that 18 assessments contained inaccuracies. An MDS modification for those assessments was completed by Staff Development Coordinator and Director of Nursing on 9/24/18. A significant correction will be completed within 14 days. An audit of the most recent MDS assessment for all residents receiving Hospice services was conducted by Staff Development Coordinator on 9/22/18 to ensure proper coding. The audit found that one assessment failed to include prognosis of 6 months or fewer to live.	

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F 641	Continued From page 7 look back period for review. Additionally, the SW revealed that she only used one function in the facility's electronic health record labeled mood and behavior when documenting. She further revealed that she was trained by the previous SW, had never reviewed the Resident Assessment Instrument (RAI) Manual and never attempted to interview Resident # 97 more than once during the look back review. The SW revealed she failed to code MDS Sections C, D, E and Q correctly for Resident # 97. Resident # 39 was admitted to the facility on 7/31/2012 with diagnoses that included osteoarthritis, chronic kidney disease stage 3 and gastroesophageal reflux disease (acid reflux). An annual review MDS assessment dated 7/11/2018 revealed Resident # 39 had minimum difficulty hearing, clear speech, the ability to express ideas and wants, the ability to understand others, adequate vision and no psychiatric or mood disorders. Resident # 39 was coded in Section C0100 as rarely/never understood. Resident # 39 was coded in Section D0100 as rarely/never understood. Section Q0100 revealed Resident # 39, family, significant other, guardian or legally authorized representative did not participate in the assessment. Section Q0550 B indicated the source of information came from Resident # 39. An interview with Resident #39 on 8/27/2018 at 10:16 AM revealed an alert and oriented resident who discussed current events. A follow up interview with Resident # 39 on 8/28/2018 at 3:25 PM revealed she was alert and	F 641	Attending physician contacted by Director of Nursing to provide appropriate prognosis documentation in order to correct the MDS assessment on 9/24/18. An MDS modification will be completed upon receiving physician□'s documentation and a significant correction will be completed within 14 days. An MDS assessment will be conducted on all residents that begin receiving Hospice services within 14 days after Hospice services are initiated. Director of Nursing and Staff Development Coordinator will audit the accuracy of Sections C, D, E, Q, and Hospice coding of 6 new MDS assessments per week for one month, 4 new MDS assessments per week for one month, and 2 new MDS Assessments per week for one month. Any inaccuracies will be corrected prior to submission and transmission by MDS Coordinator. Any trends in inaccuracies will be reviewed at monthly Quality Assurance Performance Improvement meetings and addressed by the Quality Assurance Committee. The Administrator is responsible for this Plan of Correction.	

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oriented.

A chart review of physician progress and nurses' notes during January 2018 to August 2018 revealed no mental status or sensory changes for Resident #39.

An interview with the SW on 8/30/2018 at 11:21 AM revealed it was her responsibility to complete Sections C, D, E and Q of the MDS for Resident # 39. The SW revealed that Resident # 39 did not feel well on the day she went to interview her. The SW disclosed that it was her belief when a resident is unavailable to interview or ill then the resident is coded as rarely/never understood. The SW further revealed she did not attempt to interview Resident # 39 again during the look back period for review because she did not have time. Additionally, the SW revealed that Resident # 39 was alert and oriented without any occurrences of mental status changes during the look back period.

An interview on 8/30/2018 at 4:55 PM with the MDS Coordinator revealed her signature in Section Z indicated the MDS was completed. The MDS Coordinator further revealed that she did not review the sections for accuracy. Additionally, the MDS Coordinator expected staff completing the sections to try multiple times to interview the resident during the look back period of review, to review all other disciplines documentation and to submit accurately coded sections.

An interview on 8/30/2018 at 5:40 PM with the Administrator and Campus Director revealed that both parties expected all sections of the MDS to be completed with accuracy.

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F 641	Continued From page 9	F 641		

The facility failed to accurately code mds in 4 of 21 residents reviewed for MDS coding.

Findings included:

#2. Resident # 7 was admitted to the facility on 04/22/2018 with diagnoses that included vascular dementia, bipolar disorder, anxiety, hemiplegia, depression, sleep apnea, hypertension (HTN) and benign prostatic hypertrophy (BPH).

A significant change MDS (Minimum Data Set) dated 06/04/2018 revealed that Resident # 7 had clear speech and was usually understood and usually able to understand. Resident # 7 was coded at C0100 as rarely understood and rarely able to understand and unable to participate in the Brief Interview for Mental Status (BIMs) test or the mood interview D0100 and staff interviews were conducted for C0100 and D0100 and that Resident # 7 had short and long- term memory problems. Resident # 7 was coded with no altered moods during the 14 day review period of D0500 A through J. Resident # 7 was coded at E0200 A, B and C with no behavioral symptoms and at E0800 had not rejected care during the 5 day review period. Resident # 7 was coded at Q0100 A, B and C that Resident #7, the family or significant other of Resident # 7 or the legal guardian for Resident # 7 had not participated in the assessment and at Q0500 B the MDS was coded that the family or significant other participated in the assessment of Resident #7.

A review of the Care Area Assessments (CAAs)

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F 641	Continued From page 10	F 641		

dated 06/06/2018 revealed that there were no CAAs triggered for Resident # 7 in the areas of mood state, behavioral symptoms or return to community referral.

Care plans for Resident #7 revealed a care plan initiated on 01/24/2018 that Resident # 7 had difficulty organizing thoughts and verbalizing his thoughts. The care plan goal dated 06/05/2018 was that Resident # 7 was to make his needs known effectively with interventions dated 01/24/2018 and 04/09/2018 and 08/27/2018 that included in part to ask Resident # 7 yes, no questions, to anticipate care needs and to provide verbal and non- verbal cues related to care and care needs.

A review of a social work note dated 06/01/2018 revealed that Resident #7 was unable to communicate his needs at times.

A review of nurse progress notes dated 05/22/2018 at 3:48 PM revealed that Resident # 7 was combative and refused eye drops.

A nurse progress note dated 05/29/2018 at 7:53 PM revealed that Resident # 7 refused a medication.

A nurse progress note dated 05/30/2018 at 12:56 PM revealed that Resident # 7 refused 2 medications.

A nurse progress note on 05/31/2018 at 4:25 AM revealed that Resident # 7 had yelled and when the nurse asked why he had yelled Resident # 7 responded that the sitter with his roommate did not answer him.

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A nurse progress note dated 06/01/2018 at 6:05 PM revealed that Resident # 7 refused 2 medications and spit them out.

On 06/02/2018 at 1:06 AM a nurse progress note revealed that Resident # 7 refused a medication.

A nurse progress note dated 06/02/18 at 1:33 AM revealed that Resident # 7 refused to allow a nurse assistant (NA) to obtain his vital signs.

On 06/02/2018 at 6:43 AM a nurse progress note refused a medication offered by the nurse and medication aide two times.

Nurse progress notes dated 06/02/2018 revealed that Resident # 7 refused medications at 7:07 AM, 7:08 AM and 7: 09 AM.

Resident # 7 also refused medications on 06/02/2018 at 12:49 PM and at 3:06 PM per nurse progress notes.

Nurse progress notes dated 06/03/2018 at 8:03 AM and 6:42 PM revealed that Resident # 7 refused medications at those times.

A review of a nurse progress note dated 06/04/2018 at 5:49 PM revealed that Resident # 7 refused medication and spit a medication out.

An interview with the facility social worker (SW) was conducted on 08/30/2018 at 1:40 PM. The SW revealed that it was her responsibility to complete MDS sections C, D, E and Q and to complete triggered CAAs and participate in the care plan process. The SW revealed that during the MDS review period she conducted the required interviews, reviewed only progress notes

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in the mood and behavior tab in the medical record. The SW revealed that she did not review any other medical record documents that included nurse progress notes, physician progress notes or any consults that the resident received during the look back review period. The SW explained that if any moods or behaviors were not documented in the mood or behavior area of the medical record, they were not coded on the MDS. The SW revealed that she had never read the MDS manual and had received MDS coding education from the previous SW. The SW also revealed that she only conducted resident interviews once during the review period and did not attempt resident interviews multiple times. The SW revealed that the MDS sections that she completed had been coded incorrectly for Resident # 7.

On 08/30/2018 at 4:55 PM an interview was conducted with the MDS coordinator and the Director of Nurses (DON) that revealed the MDS coordinator had only been in her position since the end of February and was still learning MDS coding. The DON revealed that she had been the MDS coordinator until two weeks ago when she was promoted to the DON position. The MDS coordinator revealed that she signed the MDS as completed after all disciplines completed the sections that they were responsible for and that each discipline was responsible to sign their MDS sections for accuracy and that her final signature was to verify that the MDS was completed. The MDS coordinator revealed that Resident # 7's communication status fluctuated multiple times every day and sometimes Resident # 7 needed to be assessed or asked questions multiple times during the review / look back period to assess his ability to answer questions. The MDS coordinator

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revealed that she did review all parts of each medical record for MDS accuracy and completion of her required sections but was not certain of the documentation that any other discipline used for MDS completion. The DON revealed that Resident # 7 was able to participate in the MDS assessment and that the SW should have returned to assess the ability of Resident # 7 to answer the questions. The DON revealed that the SW needed more education for MDS completion and accuracy.

On 08/30/2018 at 5:40 PM an interview was conducted with the facility administrator and the administrator revealed that it was expected that all sections of the MDS be completed with accuracy.

2. Resident #107 was admitted to the facility 3/20/18. The resident died at the facility on 5/30/18. The resident's admission diagnosis included lung cancer with metastases to the bone.

A review of Resident #107's Minimum Data Set (MDS) revealed the most recent completed assessment was a comprehensive admission assessment with an Assessment Reference Date (ARD) of 3/27/18. The MDS assessment indicated Resident #107 moderately impaired cognition. The resident was not coded for Hospice services. Further review of the MDS revealed the resident was not coded as having had a prognosis, condition, or chronic disease that may result in a life expectancy of less than 6 months.

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A Review was completed of Resident #107's Care Area Assessments (CAAs) from the 3/27/18 comprehensive assessment. Review of the Care Area of Activities of Daily Living (ADLs)/Functional Status revealed the following documentation, lung cancer, bone cancer, and frequent back pain, under the care of Hospice. Review of the CAAs revealed a Care Area for Activities. Review of the Activities area revealed the following documentation, Resident #107 was new to the facility. The resident was currently on Hospice support and tires easily. Further review of the CAAs revealed a Care Area for Nutrition. Review of the Nutrition area revealed the resident had experienced a significant weight decline and was likely to continue to experience weight decline due to Hospice care and cancer.

Review of Resident #107's face sheet found in the Electronic Medical Record (EMR) revealed the resident was admitted from a residential Hospice care facility. Further review revealed the resident's primary payor source from the date of admission till the date of death was Hospice.

Review of Resident #107's EMR revealed a communication sheet from the Hospice and Palliative Care provider to the Billing Coordinator of the facility. The communication sheet was a correspondence from the Hospice provider to the facility providing information Resident #107 was admitted to their Hospice services effective 3/20/18.

A review of Resident #107's physician progress notes revealed a progress note dated 3/21/18 documenting the resident was under the care of hospice and had a diagnosis of metastatic lung cancer with metastases to the bone. The note

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further documented the resident had been a resident at the local residential Hospice care facility for respite for 2 weeks prior to admission to the facility.

A review was completed of Resident #107's Plan of Care Summary dated 4/26/18 which included the baseline care plan initiated after the 3/20/18 admission. The review of the baseline care plan revealed documentation the resident required assistance to complete his ADLs due to having had lung cancer, bone cancer, and frequent back pain. There was no mention of Hospice involvement in the baseline care plan.

A review of Resident #107's nurses' notes revealed a note dated 5/30/18 and timed 9:30 AM which documented the resident passed at 9:15 AM, Hospice and the Physician's Assistant were notified.

An interview was conducted with the Billing/Accounts Receivable (AR) Specialist on 8/30/18 at 2:53 PM. The AR Specialist sated Resident #107's stay at the facility was billed to Hospice Services Provider for his whole stay from 3/20/18 through 5/30/18 due to the resident having had been admitted under Hospice Services.

An interview was completed with the Hospice Director of Regulatory Affairs on 8/30/18 at 3:11 PM. The Director reviewed the record for Resident #107 and did not discover Hospice employees had been invited to a care plan or had participated in a care plan for Resident #107. The Director confirmed the resident was receiving Hospice services.

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F 641	Continued From page 16 An interview was completed with Social Work (SW) on 8/30/18 at 4:31 PM. The SW stated Resident #107 had been admitted to the facility under Hospice Services. An interview was conducted with the MDS Coordinator on 8/30/18 at 4:55 PM. The MDS Coordinator stated Resident #107 was admitted under Hospice and received Hospice services during his whole stay at the facility. The MDS Coordinator reviewed the resident's admission MDS assessment dated 3/27/18 and stated she had not coded the resident as having had received Hospice Care. The MDS Coordinator stated the MDS should have been coded that the resident was receiving Hospice care. The MDS Coordinator further stated the resident had not been coded as having had a prognosis, condition, or chronic disease that may have resulted in a life expectancy of less than six months. An interview was conducted with the Administrator on 8/30/18 at 5:40 PM. The Administrator stated it was his expectation if a resident was receiving Hospice services then Hospice care should have been coded on that resident's MDS assessment and his expectation was for MDS assessments to have been coded correctly.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide	F 655		9/26/18

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F 655	Continued From page 17 effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, hospice representative	F 655	Minimum Data Set (MDS) Coordinator	

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F 655	Continued From page 18 interview, and staff interviews, the facility failed to include Hospice in the baseline care plan for one of one resident reviewed for death (Resident #107). Resident #107 was admitted to the facility 3/20/18. The resident died at the facility on 5/30/18. The resident's admission diagnosis included lung cancer with metastases to the bone. A review of Resident #107's Minimum Data Set (MDS) revealed the most recent completed assessment was a comprehensive admission assessment with an Assessment Reference Date (ARD) of 3/27/18. The MDS assessment indicated Resident #107 moderately impaired cognition. A Review was completed of Resident #107's Care Area Assessments (CAAs) from the 3/27/18 comprehensive assessment. Review of the Care Area of Activities of Daily Living (ADLs)/Functional Status revealed the following documentation, lung cancer, bone cancer, and frequent back pain, under the care of Hospice. Review of the CAAs revealed a Care Area for Activities. Review of the Activities area revealed the following documentation, Resident #107 was new to the facility. The resident was currently on Hospice support and tires easily. Further review of the CAAs revealed a Care Area for Nutrition. Review of the Nutrition area revealed the resident had experienced a significant weight decline and was likely to continue to experience weight decline due to Hospice care and cancer. Review of Resident #107's face sheet found in the Electronic Medical Record (EMR) revealed	F 655	failed to address the receiving of Hospice services on resident #107□'s baseline care plan due to staff error. Resident #107 passed away in the facility so his baseline care plan cannot be corrected. An audit of all baseline care plans for residents receiving Hospice services upon admission□ was conducted by Staff Development Coordinator on 9/24/18. The audit found that no new residents have been admitted to facility under Hospice care since resident #107 was admitted to the facility. MDS Coordinator was in-serviced on proper baseline care plan documentation, including the need for Hospice services to be addressed in the baseline care plan by Staff Development Coordinator on 9/24/18. MDS coordinator was provided a checklist for resident care items that should be addressed in baseline care plan. All residents that admit to the facility under Hospice care will have Hospice services addressed in their baseline care plan upon completion of the baseline care plan. Newly admitted residents including those receiving Hospice services will continue to be monitored by Interdisciplinary Team in Daily Clinical meetings and weekly Clinical Team meetings. Any failure to address receiving of Hospice services in the baseline care plan will be corrected by MDS Coordinator	

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F 655	Continued From page 19 the resident was admitted from a residential Hospice care facility. Further review revealed the resident's primary payor source from the date of admission till the date of death was Hospice. Review of Resident #107's EMR revealed a communication sheet from the Hospice and Palliative Care provider to the Billing Coordinator of the facility. The communication sheet was a correspondence from the Hospice provider to the facility providing information Resident #107 was admitted to their Hospice services effective 3/20/18. A review of Resident #107's physician progress notes revealed a progress note dated 3/21/18 documenting the resident was under the care of hospice and had a diagnosis of metastatic lung cancer with metastases to the bone. The note further documented the resident had been a resident at the local residential Hospice care facility for respite for 2 weeks prior to admission to the facility. A review was completed of Resident #107's Plan of Care Summary dated 4/26/18 which included the baseline care plan initiated after the 3/20/18 admission. The review of the baseline care plan revealed documentation the resident required assistance to complete his ADLs due to having had lung cancer, bone cancer, and frequent back pain. There was no mention of Hospice involvement in the baseline care plan. A review of Resident #107's nurses' notes revealed a note dated 5/30/18 and timed 9:30 AM which documented the resident passed at 9:15 AM, Hospice and the Physician's Assistant were notified.	F 655	at that time. Any trends in failure to address receiving of Hospice services in baseline care plans will be discussed in monthly Quality Assurance Performance Improvement meetings and addressed by the Quality Assurance committee. The Administrator is responsible for this Plan of Correction.	

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An interview was conducted with the Billing/Accounts Receivable (AR) Specialist on 8/30/18 at 2:53 PM. The AR Specialist sated Resident #107's stay at the facility was billed to Hospice Services Provider for his whole stay from 3/20/18 through 5/30/18 due to the resident having had been admitted under Hospice Services.

An interview was completed with the Hospice Director of Regulatory Affairs on 8/30/18 at 3:11 PM. The Director reviewed the record for Resident #107 and did not discover Hospice employees had been invited to a care plan or had participated in a care plan for Resident #107. The Director confirmed the resident was receiving Hospice services.

An interview was completed with Social Work (SW) on 8/30/18 at 4:31 PM. The SW stated Resident #107 had been admitted to the facility under Hospice Services. The SW reviewed the resident's baseline care plan and stated the baseline care plan did not contain information about the resident having been on Hospice.

An interview was conducted with the MDS Coordinator on 8/30/18 at 4:55 PM. The MDS Coordinator stated Resident #107 was admitted under Hospice and received Hospice services during his whole stay at the facility. The MDS Coordinator reviewed the resident's baseline care plan and stated there was information regarding Hospice in the resident's baseline care plan. The MDS Coordinator stated the resident should have had a Hospice area included in his baseline care plan.

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F 655	Continued From page 21 An interview was conducted with the Administrator on 8/30/18 at 5:40 PM. The Administrator stated it was his expectation if a resident was receiving Hospice services at the time of admission or prior to the permanent care plan having been completed then Hospice needed to be addressed in the baseline care plan.	F 655		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the	F 656		9/25/18

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F 656	Continued From page 22 resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, hospice representative interview, and staff interviews, the facility failed to collaborate with hospice to develop and implement an interdisciplinary care plan for one of one resident reviewed for death (Resident #107), failed to implement a care plan for edema and for pain for one of one resident reviewed for edema and one of two residents reviewed for pain (Resident #51), and failed to implement a care plan addressing the use of diabetic medication, anticoagulant therapy, and antidepressant therapy for one of five residents reviewed for unnecessary medication review (Resident #61). 1. Resident #107 was admitted to the facility 3/20/18. The resident died at the facility on 5/30/18. The resident's admission diagnosis included lung cancer with metastases to the bone. A review of Resident #107's Minimum Data Set (MDS) revealed the most recent completed assessment was a comprehensive admission assessment with an Assessment Reference Date	F 656	The facility has recently undergone a change in format of comprehensive care plans and during the transition some aspects of comprehensive care plans were missed. For resident #51 the facility failed to address edema and pain. For resident #61 the facility failed to address the use of anticoagulant therapy, insulin for treatment of diabetes, and the use of antidepressant medication. For resident #107 the facility failed to address the receiving of Hospice services. Resident #51□'s comprehensive care plan was updated to address the presence or risk of pain, the use of diuretic medications to treat edema, and the treatment of edema through application of unna Boots by Minimum Data Set (MDS) Coordinator on 9/24/18. Resident #61'□s comprehensive care plan was updated to include receiving of anticoagulant therapy, the use of insulin to treat diabetes, and the use of	

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F 656	Continued From page 23 (ARD) of 3/27/18. The MDS assessment indicated Resident #107 moderately impaired cognition. A Review was completed of Resident #107's Care Area Assessments (CAAs) from the 3/27/18 comprehensive assessment. Review of the Care Area of Activities of Daily Living (ADLs)/Functional Status revealed the following documentation, lung cancer, bone cancer, and frequent back pain, under the care of Hospice. Review of the CAAs revealed a Care Area for Activities. Review of the Activities area revealed the following documentation, Resident #107 was new to the facility. The resident was currently on Hospice support and tires easily. Further review of the CAAs revealed a Care Area for Nutrition. Review of the Nutrition area revealed the resident had experienced a significant weight decline and was likely to continue to experience weight decline due to Hospice care and cancer. Review of Resident #107's face sheet found in the Electronic Medical Record (EMR) revealed the resident was admitted from a residential Hospice care facility. Further review revealed the resident's primary payor source from the date of admission till the date of death was Hospice. Review of Resident #107's EMR revealed a communication sheet from the Hospice and Palliative Care provider to the Billing Coordinator of the facility. The communication sheet was a correspondence from the Hospice provider to the facility providing information Resident #107 was admitted to their Hospice services effective 3/20/18. A review completed of Resident #107's care plan	F 656	psychotropic drugs by Staff Development Coordinator on 9/22/18. Resident #107 passed away and his care plan cannot be changed. An audit of all comprehensive care plans for residents receiving Hospice services was conducted by Staff Development Coordinator on 9/22/18 to ensure that the receiving of Hospice services is incorporated on their comprehensive care plan. Audit found that no further care plans failed to address receiving of Hospice services. MDS Coordinator was in-serviced on proper care plan documentation, including the need for Hospice services to be addressed in the resident's comprehensive care plan by Staff Development Coordinator on 9/22/18. Social Worker was in-serviced on the need for Hospice Providers to attend care plan meetings and to assist in developing a Hospice specific care plan by Administrator on 9/24/18. All new Hospice orders will be reviewed by the Interdisciplinary Team in daily clinical meetings and the comprehensive care plan will be updated at that time by the MDS Coordinator. Hospice providers will share input with facility through communication books at the nurses stations. Registered Nurse (RN) Unit Mangers will review Hospice communication books and bring updates to daily clinical meeting. Any necessary	

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F 656	Continued From page 24 which had been completed after the comprehensive admission assessment with an ARD of 3/27/18 was completed on 8/30/18 at 2:04 PM. The review revealed no hospice care plan. The only discovered mention of Hospice in the resident's care plan was an isolated occurrence related to nutrition. A review of Resident #107's physician progress notes revealed a progress note dated 3/21/18 documenting the resident was under the care of hospice and had a diagnosis of metastatic lung cancer with metastases to the bone. The note further documented the resident had been a resident at the local residential Hospice care facility for respite for 2 weeks prior to admission to the facility. A review of Resident #107's nurses' notes revealed a note dated 5/30/18 and timed 9:30 AM which documented the resident passed at 9:15 AM, Hospice and the Physician's Assistant were notified. An interview was conducted with the Billing/Accounts Receivable (AR) Specialist on 8/30/18 at 2:53 PM. The AR Specialist sated Resident #107's stay at the facility was billed to Hospice Services Provider for his whole stay from 3/20/18 through 5/30/18 due to the resident having had been admitted under Hospice Services. An interview was completed with the Hospice Director of Regulatory Affairs on 8/30/18 at 3:11 PM. The Director reviewed the record for Resident #107 and did not discover Hospice employees had been invited to a care plan or had participated in a care plan for Resident #107.	F 656	changes in comprehensive care plans will be made at that time by MDS Coordinator. Residents receiving Hospice services will continue to be monitored by Interdisciplinary Team in weekly Clinical Team meetings. Any necessary comprehensive care plan updates will be made at that time by MDS Coordinator. Social worker was designated as contact person for Hospice providers, and will invite them to participate in care plan meetings to collaborate on developing residents□' comprehensive care plans. Administrator, Director of Nursing, and Social Workers met with Trellis Hospice Provider□s team to review survey findings and to discuss the process of communication and integrating Hospice plan of care into facility'□s written comprehensive care plans on 9/24/18. Administrator left voice mail message with remaining two Hospice providers (Novant Hospice and Hospice of Catawba Valley) on 9/24/18 to set up a meeting to review survey findings and discuss improving communication and integrating Hospice plan of care into facility□'s written comprehensive care plans. Those meetings will be held at Hospice Provider□s earliest availability. Director of Nursing and Staff Development Coordinator will audit comprehensive care plans of all residents receiving Hospice services to ensure Hospice services are addressed and Hospice providers are involved in the development of comprehensive care plans bi-weekly for 3 months. Any trends	

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F 656	Continued From page 25 The Director further stated the Hospice service provider had their own care plan which they reviewed during their own Interdisciplinary Care Plan Team meetings. An interview was completed with Social Work (SW) on 8/30/18 at 4:31 PM. The SW stated Resident #107 had been admitted to the facility under Hospice Services. The SW stated there had been a care plan meeting on 4/6/18 for the resident and the following people attended: Dietary Manager, SW, MDS Coordinator, the resident's family, and the Unit Manager. The SW stated there were no representatives from Hospice at the Care Plan meeting. The SW stated she would have verbally told the Hospice staff the resident was having a care plan. The SW stated she would not have sent a letter and did not have any documentation she had invited a Hospice staff member to the Care Plan for Resident #107. The SW further stated she did not think she had ever had a Hospice staff member attend a care plan for a Hospice resident. The SW stated the resident did not have a Hospice specific care plan. An interview was conducted with the MDS Coordinator on 8/30/18 at 4:55 PM. The MDS Coordinator stated Resident #107 was admitted under Hospice and received Hospice services during his whole stay. The MDS Coordinator stated they had a Care Plan meeting on 4/6/18 and there were no Hospice staff in attendance at the care plan meeting to contribute to the resident's care plan. The MDS Coordinator stated Hospice staff were invited to the care plan meetings. The MDS Coordinator further stated the SW invited the Hospice staff to the care plan meetings. The MDS Coordinator was unable to	F 656	in failure to address Hospice services will be reviewed at monthly Quality Assurance Performance Improvement meetings and addressed by the Quality Assurance committee. MDS Coordinator was in-serviced on proper care plan documentation, including the need to address conditions such as edema and swelling, and the use of diuretic medication and unna boots to treat those conditions in the resident□s' comprehensive care plan by Staff Development Coordinator on 9/22/18. MDS Coordinator was in-serviced on proper care plan documentation including the need for receiving of anticoagulant therapy, the use of medications such as insulin to treat diabetes, and the use of antidepressant medications to be addressed in the resident□s comprehensive care plan by Staff Development Coordinator on 9/22/18. MDS Coordinator was in-serviced on proper care plan documentation including the need to address the presence of pain or risk of experiencing pain on residents' comprehensive care plans by Staff Development Coordinator on 9/22/18. An audit of the comprehensive care plans for all residents who are receiving diuretic treatment for edema, anticoagulant therapy, insulin treatment for diabetes, and antidepressant medications was conducted by Staff Development Coordinator and Director of Nursing on	

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F 656	Continued From page 26 identify when the last time a Hospice staff member attended a care plan meeting for a Hospice resident. The MDS Coordinator stated she had no documentation to show Hospice staff were invited to the care plan meeting of a Hospice resident. The MDS Coordinator stated the resident did not have a Hospice specific care plan. During an interview conducted with the Staff Development Nurse on 8/30/18 at 5:39 PM she stated Hospice staff had not been invited to the care plan meetings for Hospice residents. During an interview conducted with the Administrator on 8/30/18 at 5:40 PM he stated if a resident was receiving Hospice services then it was his expectation for Hospice staff to be invited to the Care Plan meeting. The Administrator further stated if the Hospice staff members were unable to attend the Care Plan meeting there needed to be documentation in the resident's medical record the Hospice were unable to attend the resident's scheduled care plan meeting. 2. Resident #51 was originally admitted to the facility 6/1/18 and readmitted to the facility on 7/3/18. The resident's admission diagnoses included: Chronic Obstructive Pulmonary Disease (COPD), renal disease, atrial fibrillation, and congestive heart failure (CHF). A review of Resident #51's Minimum Data Set (MDS) revealed the most recent completed assessment was a comprehensive admission assessment with an Assessment Reference Date (ARD) of 7/10/18. The MDS assessment indicated Resident #51 was not cognitively impaired. The assessment indicated resident	F 656	9/23/18. Audit found that 13 residents□' comprehensive care plans failed to address receiving diuretic treatment for edema. Those residents□' comprehensive care plans were updated by Staff Development Coordinator and Director of Nursing on 9/23/18 to include receiving diuretic medication to treat edema. Audit found that 25 residents'□ comprehensive care plans failed to address receiving of anticoagulant therapy. Those resident□s' comprehensive care plans were updated by Staff Development Coordinate on 9/22/18. The audit found that 8 residents'□ comprehensive care plans failed to address receiving antidepressant drug therapy. Those residents'□ care plans were updated by the Staff Development Coordinator on 9/22/18 to include the use of antidepressant medications. The audit found that 12 residents'□ comprehensive care plans failed to address receiving insulin for treatment of diabetes. Those residents□' comprehensive care plans were updated by Staff Development Coordinator and Director of Nursing on 9/23/18 to include receiving insulin to treat diabetes. A pain assessment was completed on all residents by Registered Nurse (RN) Unit Managers, Hall Nurse, or Director of Nursing on 9/23/18 and 9/24/18. Assessments found that 23 residents□ comprehensive care plans failed to address pain. The comprehensive care plans for all residents that report experiencing pain□ or are at risk of	

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F 656	Continued From page 27 required extensive assistance of one or more people for several Activities of Daily Living including: bed mobility, transfer (such as from the bed to a wheelchair), toileting, walking, personal hygiene, dressing, and bathing. The resident was coded as having had received a diuretic (fluid) medication each of the seven days of the seven-day assessment period. A review completed of Resident #51's care plan which had been most recently updated/reviewed as of 7/13/18. The review revealed no information in the care plan regarding the resident's edema in both her legs nor her use of diuretic medication. A review of Resident #51's physician orders revealed an order for torsemide (a diuretic/fluid medication), 10 milligrams (mg), orally, once daily, with an order date of 8/5/18. The resident also had an order for spironolactone (a diuretic/fluid medication), 25 milligrams (MG), orally, once daily, with an order date of 8/21/18, and the diagnosis related to the medication was edema. Further review revealed a treatment order for Unna boots (a compression dressing which has zinc oxide paste applied to the dressing) to be applied to both legs, two times per week for the diagnosis of edema. The order for the Unna boots was dated 8/23/18. Review of Resident #51's Medication Administration Record (MAR) for the period of August 1, 2018 through August 30, 2018 was conducted. Review of the MAR revealed the resident had received 20 mg of torsemide, 2 10 mg tablets, orally, once daily, for edema, with an entry date of 7/31/18, from 8/1/18 through 8/4/18. Continued review of the MAR revealed the	F 656	experiencing pain was updated to address the presence of or risk for pain by Staff Development Coordinator on 9/24/18. All new orders for use of diuretic medications for treatment of edema, anticoagulant therapy, insulin treatment for diabetes, and receiving of antidepressant medications will be reviewed by the Interdisciplinary Team in daily clinical meetings and the comprehensive care plan will be updated to reflect receiving diuretic treatment for edema, anticoagulant therapy, insulin treatment for diabetes, and antidepressant medications at that time by the MDS Coordinator. All residents that report pain during a pain assessment, receive a new order for pain medication, or begin receiving PRN pain medication will be monitored by Interdisciplinary Team in daily clinical meetings and in weekly clinical team meetings. Any appropriate comprehensive care plan updates to address pain will be made at that time by the MDS Coordinator. Director of Nursing and Staff Development Coordinator will audit 6 comprehensive care plans per week for one month, 4 comprehensive care plans per week for one month, and 2 comprehensive care plans per week for one month to ensure the comprehensive care plan appropriately addresses the receiving of diuretic treatment for edema, anticoagulant therapy, insulin treatment	

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F 656	Continued From page 28 resident had received torsemide (a diuretic, 10 mg, orally, once daily, for edema, from August 5, 2018 through August 29, 2018 and the dose on August 30, 2018 was held. Further review of the MAR review revealed the resident received spironolactone (a diuretic) from August 21, 2018 through August 29, 2018 and the August 30, 2018 dose was held. Review of Resident #51's MAR for treatments revealed orders for the application of elasticated tubular bandages, double, over both legs, when the resident was out of bed each morning and to be removed each evening for edema and the order was received from the wound center. The elasticated tubular bandages were applied from 8/8/18 through 8/23/18. Further review revealed the resident had entries for Unna boots to be applied to the resident's legs to treat edema on 8/20/18, 8/21/18, and 8/23/18. It was documented the Unna boots were applied on 8/22/18, 8/24/18, and 8/28/18. An interview and observation conducted with Resident #51 on 8/28/18 at 10:06 AM revealed the resident had visible swelling in both feet. The resident stated the nurses wrapped her feet to help minimize the swelling. An interview was conducted with the Wound Nurse on 8/30/18 at 9:25 AM. The Wound Nurse stated the Resident #51's Unna boots get changed twice per week. The wound nurse stated the resident's Unna boots are removed on her shower days, prior to her receiving a shower, and a new set of Unna boots are applied the day after the resident's shower. The Wound Nurse stated the overnight break allow the resident's legs to "breathe" a little bit. The Wound Nurse	F 656	for diabetes, antidepressant medications, or the control of pain. Any inaccuracies will be corrected by Director of Nursing or Staff Development Coordinator. Any trends in inaccuracies will be reviewed at monthly Quality Assurance Performance Improvement meetings and addressed by the Quality Assurance Committee. The Administrator is responsible for this Plan of Correction.	

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stated the resident did have complaints of pain in her legs at times and the resident had received as needed pain medication for her complaints of pain.

An interview and observation conducted with Resident #51 on 8/30/18 at 10:33 AM revealed the resident had visible swelling in both feet. The resident stated the nurses wrapped her feet a little while ago. The resident stated she had a lot of swelling in her knees and her legs.

An observation was conducted of Nurse #4 providing care for Resident #51 on 8/30/18 at 11:20 AM. The nurse removed the resident's socks and was observed palpating the resident's toes. The resident's toes appeared edematous and the nurse's finger was observed pressing against the edema in the resident's foot during palpation. In addition to edema at the resident's feet the nurse was observed to palpate and assess for edema at the resident's knees.

An interview was conducted with Nurse #4 on 8/30/18 at 11:25 AM. The nurse stated Resident #51 did not like the Unna boots but the treatment nurse did a really good job with the resident and the resident would comply with wearing the Unna boots for the treatment nurse. The nurse stated she would inform Unit Nurse Manager #1 about the resident's concerns about the swelling in her knees and feet.

An interview was conducted with the MDS Coordinator on 8/30/18 at 4:55 PM. The MDS Coordinator stated Resident #51 had an order for Unna boots and the resident had experienced some pain and discomfort related to the Unna boots and swelling. The MDS Coordinator stated

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there were not care plans for the resident related to her edema, swelling, use of diuretics, or the use of Unna boots to treat the resident's edema. The MDS Coordinator stated she should have addressed the treatment for the resident's legs, the resident's edema, discomfort from the swelling, or the treatment for her edema, such as the use of the Unna boots in the resident's care plan.

During an interview conducted with the Administrator on 8/30/18 at 5:40 PM he stated it was his expectation for care plans to address resident treatments and/or conditions such as conditions such as edema and swelling and the treatments for those conditions. The Administrator further stated there needed to be applicable goals in the resident's care plans related to the identified conditions.

3. Resident #61 was admitted to the facility 9/21/12. The resident's diagnoses include: Multiple Sclerosis (MS), diabetes, depression, and a history of venous thrombosis/embolism (blood clots).

A review of Resident #61's Minimum Data Set (MDS) revealed the most recent completed assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 7/19/18. The MDS assessment indicated Resident #51 was not cognitively impaired. The assessment indicated resident required extensive assistance of one or more people for several Activities of Daily Living including: bed mobility, transfer (such as from the bed to a wheelchair), toileting, walking, personal hygiene, dressing, and bathing. The resident was coded as having had received an insulin injection, antidepressant, and

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anticoagulant each day of the seven-day assessment period

A review completed of Resident #61's care plan which had been most recently updated/reviewed as of 7/23/18. The review revealed no information in the care plan regarding the resident's use of insulin or other diabetic medication, anticoagulant therapy, or the use of psychotropic medications.

A review of Resident #61's physician orders revealed an order for duloxetine hydrochloride (HCl) (antidepressant) 60 milligrams (mg) delayed release particles, one capsule, once daily, orally, to treat depression, the medication start date was documented as 2/18/16. In addition the resident was prescribed to receive duloxetine HCl 30 mg delayed release particles, one capsule, each evening at bedtime, orally, to treat depression, the medication start date was documented as 8/19/16. Further review of the physician's orders revealed the resident was prescribed to receive Apixaban (anticoagulant/blood thinner) 5 mg, orally, twice per day, as anticoagulation therapy, with a documented medication start date of 11/17/17. The resident was prescribed to receive metformin HCl 1,000 mg, orally, twice per day, for a diagnosis of diabetes. The medication was documented to have had a start date of 1/11/18. The resident had a physician order for Insulin lispro, pen, 100 unit/milliliter (ml), and was to receive 15 units subcutaneously (SQ) daily for supper, for diabetes. The order date was 7/23/18. The resident had a physician order for insulin glargine 300 unit/ml, with a dose of 65 units, SQ, daily, at bedtime, for diabetes. The order had a start date of 8/17/18. The resident

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F 656	Continued From page 32	F 656		

had a physician order for insulin lispro 100 unit/ml solution pen injector, dose of 10 units, SQ, three times a day, upon rising, at lunch, and at bedtime. The diagnosis was diabetes. The medication had a start date of 7/23/18.

Review of Resident #61's Medication Administration Record (MAR) for the period of August 1, 2018 through August 30, 2018 was conducted. Review of the MAR revealed the resident had received the following medications on multiple dates during the reviewed period: Insulin lispro-for diabetes, duloxetine-for depression, Apixaban-for anticoagulant therapy, and metformin HCL-for diabetes, insulin glargine-for diabetes.

An interview was conducted with the MDS Coordinator on 8/30/18 at 4:55 PM. The MDS Coordinator stated Resident #61 was on anticoagulant, diabetic medications, and antidepressant. The MDS Coordinator stated she was unable to find a care plan which addressed the resident's use of anticoagulants, diabetic medications, or the use of antidepressants in the resident's care plan. The MDS Coordinator stated the resident should have had a care plan for the use of anticoagulant medication, the use of a diabetic medication-such as insulin, and the use of a psychotropic medication-such as an antidepressant.

During an interview conducted with the Administrator on 8/30/18 at 5:40 PM he stated it was his expectation for care plans to address resident medications such as anticoagulants, antidepressants, and diabetic medications. The Administrator further stated there needed to be applicable goals in the resident's care plans

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F 656	Continued From page 33 related to the resident's medications.	F 656		
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 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 resident interview, staff interviews, and record review the facility failed to invite one of one resident to participate in her care plan review meeting who had been investigated for care planning (Resident #59).	F 657	The facility failed to invite Resident #59 to her care plan due to staff error and system failure. Minimum Data Set (MDS) Coordinator generates a list of residents with MDS assessments due. That list was	9/27/18

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F 657	Continued From page 34 The findings included: Resident #59 was admitted 5/31/17. The resident's admission diagnoses included: shoulder surgery, kidney disease, Chronic Obstructive Pulmonary Disease (COPD), and arthritis. Review of Resident #59's most recent Minimum Data Sheet (MDS) assessment revealed a quarterly assessment with an Assessment Reference Date (ARD) of 7/19/18. The resident was coded as having had no cognitive impairment. The resident was not coded for any moods or behaviors. A review of Resident #59's care plan, which had been most recently reviewed and updated on 7/24/18, was completed. There was a problem with a date of 6/29/18 which was documented as, the resident was content with her active involvement and attendance level with pursuits of her choice. The resident was independent with her pursuits and her daily routine. The resident had many different interests that she preferred to pursue in her room, attend social events throughout the month as scheduled. The goal was listed as the resident would express satisfaction with independent pursuits and will affirm that she did not feel lonesome and attend select groups of interest as scheduled with staff assistance. Review of the residents Electronic Medical Record (EMR) revealed a Social Work (SW) progress note dated 7/19/18 and timed 4:10 PM. The note documented the SW visited the resident in her room and the resident was alert and	F 657	given to the receptionist to notify residents and their responsible parties to participate in their care plan meeting. Receptionist was unable to complete this task effectively. The facility scheduled Resident #59 a care plan meeting for 9/24/18. Resident #59 and her daughter were invited and plan to attend. An audit of receptionist's care plan meeting invitation book and care plan meeting notes from residents' most recent care plan meeting was conducted by Administrator on 9/23/18. The audit found that the facility failed to invite 20 residents to participate in their care plan meeting. Those residents were offered the opportunity to participate in a care plan meeting on 9/24/18 by the Administrator and Social Worker. Of those 20 residents three wished to schedule a care plan meeting rather than wait for their next care plan meeting. Two are scheduled for 9/26/18 and one is scheduled for 9/27/18. The responsibility of inviting residents and their responsible parties to care plan meetings was taken from receptionist and given to Social Workers on 9/24/18. MDS Coordinator will generate a list of residents with assessments due weekly. Social Workers will use list to invite residents and residents families to attend care plan meetings and participate in development of comprehensive care plans to the extent practicable. If it is not practicable for resident or resident s	

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TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

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F 657	Continued From page 35 oriented to person, place, time, and situation. The resident was documented as having been able to verbalize wants/needs in a clear manner. It was further documented the resident participated in many activities and outings. The resident was documented as having been pleasant and cooperative. It was documented the resident had expressed a concern about not having been as mobile as she had been in the past. The note documented the resident had knee issues and the resident's family did not want to consider surgery due to the resident's surgical history. The SW documented she would talk to the Life Enrichment about the possibility of the resident utilizing the pool. A review of the Case Mix Care Plan meeting schedule the Concierge/Receptionist (CR) utilized for inviting resident families from 6/24/18 through 8/18/18. The review revealed Resident #59 was scheduled for a care plan on 7/25/18. Review of the Care Plans Schedules sheet the CR had completed for care plan meetings on 7/25/18 revealed no scheduled care plans for Resident #59 nor her family. Further review of the other care plan meetings held from 7/3/18 through 8/22/18 revealed no scheduled care plan meetings for Oma Eagle nor her family. During an interview conducted with Resident #59 conducted on 8/28/18 at 9:11 AM, the resident stated she had not received an invitation to a care plan meeting and she would like to participate in her care plan meeting. An interview was conducted with the facility Social Worker (SW) on 8/29/18 at 3:30 PM. The SW stated she used to conduct the invitations for care plan meetings. The SW stated when she did the	F 657	family to attend care plan meeting or participate in the development of comprehensive care plan, an explanation will be included in the resident□s medical record. Social Workers and MDS Coordinator were in-serviced on care plan timing and revision regulations, specifically the importance of inviting residents and their responsible parties to attend their care plan meetings, and the facility's new care plan procedures by the Administrator on 9/27/18. The Administrator will audit care plan meeting notes to ensure residents, their families or responsible parties are invited to participate in care plan meeting for 5 residents per week for one month, 3 residents per week for one month, and 2 residents per week for one month. Any trend in failure to invited residents, their family or responsible party to attend care plan meetings will be discussed in monthly Quality Assurance Performance Improvement meetings and addressed by the Quality Assurance Committee. The Administrator is responsible for this Plan of Correction.	

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invitations she would call and do a note in the Electronic Medical Record (EMR) as a care conference note. She stated she would document she asked if there was a need for care conference meeting with the team including: dietary, a Nursing Assistant (NA) who had been assigned to the resident, social work, and activities. The SW stated the receptionist had taken over inviting conducting the invitations to the care plan meeting. The SW stated the family of the resident or the resident themselves were invited to the care plan meeting. The SW stated if the resident had cognitive loss then the resident's then the resident's family would be invited to the care plan meeting. The SW further stated if the resident did not have cognitive loss then they would talk to the resident and ask the resident if they wanted to participate in a care plan meeting. The SW stated she did not remember when the receptionist had started to conduct the care plan meeting invitations. The SW stated the receptionist may have started to conduct the care plan meeting invitations in January, February, or the first of the year. The SW stated they usually had 3-5 care plan meetings per week and the meetings are usually on Wednesdays. The SW further stated if a family member or resident had wanted to schedule a care plan meeting on another day beside Wednesday they would do their best to accommodate the request.

An interview was conducted with the Concierge/Receptionist (CR) on 8/29/18 at 3:39 PM. The CR stated she was conducting the invitations for participation in care plans. The CR stated every two weeks she received a list of all of the resident who were scheduled for care plan meetings for the week. The CR stated the list is

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created by the SW or the MDS Coordinator. The CR stated she had been conducting the care plan invitations since February 2018. The CR stated she called the family of a resident scheduled for a care plan meeting and would invite them to the care plan meeting. The CR stated she had a book where she had documented the names of the family members she had called and when she had called them. The CR stated if there was a resident who was alert and oriented then the SW would invite the resident to the care plan meeting.

An interview was conducted with the MDS Coordinator on 8/29/18 at 3:53 PM. The MDS Coordinator stated long-term residents were reviewed quarterly, the resident and/or the resident's family/Power of Attorney (POA) were invited to the care plan meeting the week after the resident assessment. The MDS Coordinator further stated if the resident chooses, the care plan meeting could also be held in a resident's room for their convenience. In addition, the MDS Coordinator stated, they have conducted care plan meetings over the phone for family members for their convenience. The MDS Coordinator stated most residents attend their care plan meeting because the residents want to have a voice. The MDS Coordinator stated the most recent care plan meeting note she was able to discover for Resident #59 was in November 2017. The MDS Coordinator stated Resident #59 had had three care plan meetings in 2018. The MDS Coordinator stated the most recent MDS assessment had an ARD of 7/19/18 and it was a quarterly assessment. The MDS Coordinator stated there was no note regarding the care plan meeting for Resident #59 related to the 7/19/18 assessment. The MDS Coordinator stated sometimes SW had made a note to document if a

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resident had attended a care plan but she had no documentation to show Resident #59 had attended her care plan meeting or who had attended her care plan meeting.

A second interview was conducted with the SW on 8/29/18 at 4:27 PM. The SW stated she had not called Resident #59's family to invite them to the care plan meeting because Resident #59 was alert and oriented. The SW stated Resident #59 was asked if she had wanted to attend the care plan meeting related to her assessment in July and the resident stated no. The SW stated due to the resident having responded she had not wanted to attend her care plan meeting the resident's family was not invited. The SW stated she would have asked the resident about attending the care plan meeting near the first of July but she did not have a note documenting she had asked the resident to attend the care plan meeting and the resident had declined. The SW stated she did not document inviting the resident to the care plan meeting and did not document the resident refusing to attend the care plan meeting. The SW stated she probably told the CR and the CR may have documented the care plan meeting attendance refusal. The SW stated she did not remember the last time Resident #59 had attended a care plan meeting. The SW stated the resident may have attended a care plan meeting when the resident had changed hallways but she was unable to locate documentation in the EMR regarding the resident having attended a care plan meeting.

During an interview conducted with the Administrator on 8/30/18 at 5:40 PM the Administrator stated it was his expectation that alert and oriented resident be invited to their care

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F 657	Continued From page 39 plan meeting. The Administrator further added in the event a resident refused to attend their care plan meeting, there needed to be documentation about the resident having had refused to attend their care	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, hospice representative interview, and staff interviews, the facility failed to ensure quality of care for the care plan development for one of one resident reviewed for death (Resident #107). Resident #107 was admitted to the facility 3/20/18. The resident died at the facility on 5/30/18. The resident's admission diagnosis included lung cancer with metastases to the bone. A review of Resident #107's Minimum Data Set (MDS) revealed the most recent completed assessment was a comprehensive admission assessment with an Assessment Reference Date (ARD) of 3/27/18. The MDS assessment indicated Resident #107 moderately impaired cognition.	F 684	The facility failed to ensure quality of care for the care plan development of one resident. The facility has recently undergone a change in format of comprehensive care plans and during the transition some aspects of comprehensive care plans were missed. Resident #107 passed away, therefore his care plan cannot be updated. An audit of all residents receiving Hospice services comprehensive care plan was conducted by Staff Development Coordinator on 9/22/18 to ensure that the receiving of Hospice service was addressed on the resident s comprehensive care plan. Audit found no further care plans failed to address	9/27/18

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F 684	Continued From page 40 A Review was completed of Resident #107's Care Area Assessments (CAAs) from the 3/27/18 comprehensive assessment. Review of the Care Area of Activities of Daily Living (ADLs)/Functional Status revealed the following documentation, lung cancer, bone cancer, and frequent back pain, under the care of Hospice. Review of the CAAs revealed a Care Area for Activities. Review of the Activities area revealed the following documentation, Resident #107 was new to the facility. The resident was currently on Hospice support and tires easily. Further review of the CAAs revealed a Care Area for Nutrition. Review of the Nutrition area revealed the resident had experienced a significant weight decline and was likely to continue to experience weight decline due to Hospice care and cancer. Review of Resident #107's face sheet found in the Electronic Medical Record (EMR) revealed the resident was admitted from a residential Hospice care facility. Further review revealed the resident's primary payor source from the date of admission till the date of death was Hospice. Review of Resident #107's EMR revealed a communication sheet from the Hospice and Palliative Care provider to the Billing Coordinator of the facility. The communication sheet was a correspondence from the Hospice provider to the facility providing information Resident #107 was admitted to their Hospice services effective 3/20/18. A review completed of Resident #107's care plan which had been completed after the comprehensive admission assessment with an ARD of 3/27/18 was completed on 8/30/18 at	F 684	receiving of Hospice services. Minimum Data Set (MDS) Coordinator was in-serviced on proper care plan documentation, including the need for Hospice services to be addressed in resident□s' comprehensive care plan by Staff Development Coordinator on 9/24/18. Social Worker was in-serviced on the need for Hospice Provider□s to attend care plan meetings and to assist in developing a Hospice specific care plan by Administrator on 9/24/18. All new Hospice orders will be reviewed by the Interdisciplinary Team in daily clinical meetings and the comprehensive care plan will be updated at that time by the MDS Coordinator. Hospice providers will share input with facility through communication books at nurses stations. Registered Nurse (RN) Unit Mangers will review Hospice communication books and bring updates to daily clinical meeting for review. Any necessary changes in comprehensive care plans will be made at that time by MDS Coordinator. Residents receiving Hospice services will continue to be monitored by Interdisciplinary Team in weekly Clinical Team meetings. Any necessary comprehensive care plan updates will be made at that time by MDS Coordinator. Social Worker was designated as contact person for Hospice providers, and will invite them to participate in care plan meetings to collaborate on developing residents□	

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F 684	Continued From page 41 2:04 PM. The review revealed no hospice care plan. The only discovered mention of Hospice in the resident's care plan was an isolated occurrence related to nutrition. A review of Resident #107's physician progress notes revealed a progress note dated 3/21/18 documenting the resident was under the care of hospice and had a diagnosis of metastatic lung cancer with metastases to the bone. The note further documented the resident had been a resident at the local residential Hospice care facility for respite for 2 weeks prior to admission to the facility. A review of Resident #107's nurses' notes revealed a note dated 5/30/18 and timed 9:30 AM which documented the resident passed at 9:15 AM, Hospice and the Physician's Assistant were notified. An interview was conducted with the Billing/Accounts Receivable (AR) Specialist on 8/30/18 at 2:53 PM. The AR Specialist sated Resident #107's stay at the facility was billed to Hospice Services Provider for his whole stay from 3/20/18 through 5/30/18 due to the resident having had been admitted under Hospice Services. An interview was completed with the Hospice Director of Regulatory Affairs on 8/30/18 at 3:11 PM. The Director reviewed the record for Resident #107 and did not discover Hospice employees had been invited to a care plan or had participated in a care plan for Resident #107. The Director confirmed the resident was receiving Hospice services.	F 684	comprehensive care plan. Administrator, Director of Nursing, and Social Workers met with Trellis Hospice Provider□s care team to review survey findings and to discuss the process of communication and integrating Hospice plan of care into facility□'s written comprehensive care plans on 9/24/18. Administrator left voice mail message with remaining two Hospice providers (Novant Hospice and Hospice of Catawba Valley) on 9/24/18 to set up a meeting to review survey findings and discuss ways to improve communication and integrate Hospice plan of care into facility'□s written comprehensive care plans. Those meetings will be held at Hospice provider□s earliest availability. Director of Nursing and Staff Development Coordinator will audit comprehensive care plans of all residents receiving Hospice services to ensure Hospice services are addressed and Hospice providers are involved in the development of comprehensive care plans bi-weekly for 3 months. Any trends in failure to address Hospice services will be reviewed at monthly Quality Assurance Performance Improvement meetings and addressed by the Quality Assurance Committee. The Administrator is responsible for this Plan of Correction.	

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F 684	Continued From page 42 An interview was completed with Social Work (SW) on 8/30/18 at 4:31 PM. The SW stated Resident #107 had been admitted to the facility under Hospice Services. The SW reviewed the resident's care plan initiated after the 3/27/18 comprehensive assessment and stated the resident's care plan did not have problem or care plan area for Hospice. The SW stated the care plan had been created by the MDS Coordinator. An interview was conducted with the MDS Coordinator on 8/30/18 at 4:55 PM. The MDS Coordinator stated Resident #107 was admitted under Hospice and received Hospice services during his whole stay at the facility and should have had a Hospice care plan in his permanent care plan. During an interview conducted with the Administrator on 8/30/18 at 5:40 PM he stated it was his expectation if a resident was receiving Hospice services then the resident needed to have a care plan approach or problem specifically addressing Hospice.	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 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and	F 689	Due to staff error and equipment	9/27/18

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F 689	Continued From page 43 record review, the facility failed to maintain water temperatures at or less than 116 degrees Fahrenheit (F) in two of two resident accessible visitors' bathrooms (men's bathroom and women's bathroom near the lobby). The findings included: An observation conducted on 8/29/18 at 8:57 AM was the hot water in the hand wash sink, on the right, from the faucet, in the men's bathroom, was found to be very hot and uncomfortable to the touch after a brief exposure. Skin contact with the water caused temporary redness. The bathroom was observed to have had two call light pull stations. The bathroom was located near the lobby on the corridor toward the C, D, and E Halls. The door to the men's room was not locked. The door was a push and open door with no latching mechanism. There was no key or code required to enter the bathroom which made the bathroom resident accessible. There was no signage inside the bathroom or outside of the bathroom denoting the bathroom was not for resident use. There were two stalls containing commodes and one commode was set up to be handicap accessible. An observation conducted on 8/29/18 at 9:06 AM revealed the hot water temperature in the hand wash on the right in the men's bathroom to be 127.4 degrees when tested with a thermometer. An observation conducted on 8/29/18 at 1:56 PM revealed the hot water in the women's rest bathroom hand wash sink, from the faucet, was found to be uncomfortably hot. It was noted after a brief exposure of the water on skin caused the skin of the hands to become temporarily pink	F 689	malfunction the facility failed to maintain safe water temperature of less than 116 degrees in public/guest restroom that is accessible to residents. Unsafe temperatures were not detected by the facility due to public/guest bathrooms not being on a monitoring schedule. The Maintenance Technician adjusted the mixing valve for the hot water in the public/guest bathrooms on 8/29/18. After adjusting the mixing valve, the water temperature in the bathrooms dropped to 107 degrees. Due to frequent fluctuation in temperatures a new mixing valve for the public/guest bathrooms was ordered on 9/10/18 and will be installed by Maintenance Technician upon arrival. Public/guest bathroom water temperature was added to weekly water temperature audits. Maintenance Staff were in-serviced on the need for water temperatures in resident accessible bathrooms to be lower than 116 degrees and water updated temperature monitoring schedule by Administrator on 9/24/18. The water temperature in the public/guest bathrooms will be monitored twice daily by the facility Maintenance Technician or a Maintenance designee 5 days a week for one month, then once daily five days a week for two months. If the temperature is found to be over 116 degrees the mixing valve will be adjusted and the water temperature re-tested until the temperature is less than 116 degrees.	

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F 689	Continued From page 44 after a brief exposure. An interview and record review conducted on 8/29/18 at 4:54 PM with the Campus Maintenance Director (CMD). The CMD stated water temperatures for the facility were conducted weekly and were conducted by the maintenance staff of the facility. Review of the Water/Refrigeration Temperature Reports for the facility revealed water temperatures recorded in resident rooms and resident showers where residents were exposed to hot water. In addition, review of the temperature reports revealed water temperatures were checked in nonresident areas such as the kitchen and laundry. Review of the temperature reports for the month of August revealed no hot water temperatures recorded for the men's nor women's visitor bathrooms. An interview was conducted with the CMD on 8/29/18 at 5:03 PM in conjunction with an observation of the hot water temperature in the men's bathroom, at the faucet, for the sink on the right. The temperature was recorded by utilizing the thermometer the CMD stated was utilized to check the water temperatures for the facility. A cup was placed in the sink and the hot water was allowed to run continuously into the cup. The temperature probe was placed into the cup of continuous water and the observed temperature was 129.0 degrees. The CMD stated the hot water in the guest bathrooms were checked routinely but he did not have a report or log of the temperature of the hot water from the guest bathrooms. The CMD stated the hot water for the guest bathrooms was supplied by a boiler which also supplied hot water for the kitchen. The CMD further stated in order to decrease the temperature of the hot water coming out of the	F 689	Any trend in public/guest bathroom water temperatures being over 116 degrees will be discussed in monthly Quality Assurance Performance Improvement meetings and addressed by the Quality Assurance Committee. The Administrator is responsible for this Plan of Correction.	

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faucet in the guest bathrooms there was a mixing valve (a thermostatic hot and cold water mixing valve which is designed to maintain and limit hot water to a selectable temperature) between the hot water line coming from the boiler before the water reached the guest bathroom. The CMD stated the Maintenance Technician (MT) was the person who was responsible for checking water temperatures in the facility and adjusting the mixing valve as needed. The CMD stated the water coming out of the hot water faucets which residents have access to should be a maximum of 116 degrees Fahrenheit (F). The CMD stated the visitor men's and women's bathroom were accessible for residents.

An observation was conducted with the CMD on 8/29/18 at 5:12 PM of the hot water temperature in the men's bathroom, at the faucet, for the sink on the right. The observed temperature utilizing the facility thermometer utilizing the same technique as at 5:03 PM was 129.9 degrees F.

An interview was conducted with the MT on 8/29/18 at 5:13 PM. The MT stated he was responsible for adjusting the mixing valves in the facility to make sure the maximum temperature of hot water at the faucet for resident accessible areas does not exceed 116 degrees. The MT stated he did not normally check the temperature of the hot water coming out of the faucets in the guest bathrooms. The MT stated he had not adjusted the mixing valve for the hot water supply for the guest bathrooms since most recent health department inspection. The MT stated he did not remember the date of the most recent health department inspection. The MT stated the mixing valve for the hot water supply for the guest bathrooms was above the ceiling of the

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F 689	Continued From page 46 bathrooms. The MT stated he was the person responsible for obtaining hot water temperatures throughout the facility. The MT stated he would adjust the mixing valve supplying the hot water to the guest bathrooms immediately. An interview was conducted with the MT on 8/30/18 at 11:45 AM. The MT stated the mixing valve supplying the hot water for the guest bathrooms was adjusted immediately after it was discovered the hot water coming out of the faucet exceeded 116 degrees. The MT stated after the mixing valve was adjusted the temperature of the water from the hot water faucet in the guest bathrooms was 107 degrees F. The MT stated the water temperature in the guest bathrooms was going to be tested daily until it was verified the hot water temperature at the faucet was being maintained in an acceptable and safe range. The MT stated he had scheduled time off on 8/31/18, 9/1/18, 9/2/18, and 9/3/18. The MT stated in his absence there would be an assigned person to check the water temperatures in the guest bathroom and he was scheduled to return on 9/4/18 and would resume the water temperature checks. During an interview with the Administrator on 8/30/18 at 5:40 PM, he stated it was his expectation for hot water temperatures for all resident accessible areas to not exceed 116 degrees F.	F 689		
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily	F 732		9/26/18

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	345153	A. BUILDING _____ B. WING _____	C 08/30/2018

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F 732	Continued From page 47 basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to post daily nurse staffing information in the facility 8/23/18 to 8/27/18.	F 732	Nurse staffing sheets were missing for 5 days due to Nurse Scheduler leaving for vacation without posting staffing sheets or designating another staff member to post	

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F 732	Continued From page 48 Findings included: An observation of the posted Nurse Staffing on 8/27/18 at 6:15 am revealed the last posted Nurse Staffing sheet was dated 8/22/18. A second observation on 8/27/18 at 7:41 am revealed the posted Nurse Staffing had not been updated and continued to be dated 8/22/18. On 8/30/18 at 1:45 pm an interview with the Director of Nursing revealed the Scheduler and Nursing Secretary were responsible for updating and posting the Nurse Staffing daily. The Director of Nursing stated she was aware the Staffing Sheets posted on 8/27/18 were dated 8/22/18. She stated she did not know why the staffing sheets had not been completed since 8/22/18 but her expectation is they should be completed and posted daily. An interview with the Scheduler on 8/30/18 at 2:00 pm revealed the Nursing Secretary was the person that was responsible for posting the Nurse Staffing daily. She stated the Nursing Secretary had been on vacation last week and the Nurse Staffing had not been completed in her absence on 8/23/18, 8/24/18, 8/25/18, 8/26/18, and 8/27/18. An interview on 8/30/18 at 2:05 pm with the Nursing Secretary revealed she had been on vacation last week and there was not a system in place to ensure the Nurse Staffing was completed in her absence. She stated she would be coordinating with the Scheduler, and the scheduler would be completing the Nurse Staffing when she was not available.	F 732	staffing sheets. The nurse staffing sheets were updated, and corrected on 8/27/18 by the Nurse Scheduler. Nurse Scheduler in-serviced on posting requirements and procedures by Administrator and Director of Nursing on 9/5/18. A/B Wing Weekend Unit Manager, Third Shift RN Supervisor in-service on updating posted staffing procedures will be completed no later than 9/26/18 by Administrator or Director of Nursing. The Nurse Scheduler, Director of Nursing, Third Shift RN Supervisor, or A/B Wing Weekend Unit Manger will post nurse staffing sheets daily and make corrections to sheets as staffing levels change. The Director of Nursing or Administrator will audit nurse staffing sheets for accuracy 5 days a week for one month, 3 days a week for one month, and one day a week for one month. Any trends from audit will be monitored at monthly QAPI meetings. Any trends will be addressed by QA Committee.	

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F 880	Continued From page 49	F 880		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880		9/27/18

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F 880	Continued From page 50 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and review of the facility's Infection Control Program, the facility failed to handle soiled linens, failed to clean and sanitize hands and failed to handle personal protective equipment, according to their infection control policy by leaving open bags of soiled linen in the hallway of 1 of 5 units observed (C Unit), not sanitizing hands after care in a contact isolation room and not removing personal	F 880	Staff failed to properly follow facility □'s infection control policies and procedures. All full time nursing and environmental services staff were in-serviced on Infection Control, including; proper hand hygiene, proper handling of linens, and proper use of personal protective equipment by Staff Development	

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F 880	Continued From page 51 protective equipment prior to exiting a contact isolation room. Findings included: The facility's "Infection Control Program" policy dated 12/04/2015, read in part: -"Infection control policies and practices are intended to facilitate maintaining safe, sanitary and comfortable environment - Components of the program include but are not limited to proper storage and handling of linens and waste, proper hand hygiene, use of personal protective measures and standard and transmission-based precautions - Staff members are provided instruction on infection control" 1. An observation on 8/27/2018 at 6:10 AM revealed five, medium sized, open bags of soiled linen on the C Unit, in the hallway outside of rooms C-01, C-03, C-05, C-06 and C-08. An interview on 8/27/2018 at 6:12 AM with Nurse Aide (NA) #1 revealed she did not know of the infection control policy or procedures on how to handle soiled utility. An interview on 8/27/2018 at 6:18 AM with NA #2 revealed she bagged soiled items in the room and took them to the soiled utility room on D Unit. NA # 2 further revealed she had completed infection control training and no staff was to ever leave soiled items on the floor in the hallway. An interview on 8/27/2018 at 6:26 AM with NA # 3 revealed soiled linen should be taken to the soiled linen room. NA #3 further revealed she kept clean trash bags on her, secured soiled bags in the resident's rooms and then took to the soiled utility room. NA #3 disclosed that staff was not supposed to have soiled or dirty linen in the hallway or on the floor, as she pointed out, in front	F 880	Coordinator (SDC) and Infection Preventionist (IP) by 9/27/18. All part time staff will be in-serviced prior to assuming their next work assignment. All staff are educated on proper infection control procedures, including handwashing, handling of linen, and personal protective equipment during orientation and annually. Staff Development Coordinator, Infection Preventionist, Treatment Nurse, Director of Nursing, or Registered Nurse Unit Mangers will conduct observational audits of hand washing techniques of 1 Nurse and 1 Nurse Aide per shift for 5 days a week for one month, 3 days a week for one month, and 1 day a week for one month. Staff Development Coordinator, Infection Preventionist, Treatment Nurse, Director of Nursing, or RN Unit Mangers will conduct observational audits of hand washing techniques of 1 Housekeeper per day for 5 days a week for one month, 3 days a week for one month, and 1 day a week for one month. Staff Development Coordinator, Infection Preventionist, Treatment Nurse, Director of Nursing, or RN Unit Mangers will conduct observational audits of linen handling technique of 1 Nurse and 1 Nurse Aide per shift for 5 days a week for one month, 3 days a week for one month, and 1 day a week for one month. Staff Development Coordinator, Infection	

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F 880	Continued From page 52 of Room C-01 during the interview. A follow up interview on 8/27/2018 at 6:43 AM with NA #1 revealed she did not recall any training on infection control policy or isolation during her recent new hire orientation. NA # 1 revealed that isolation rooms have biohazard bags in the rooms. NA #1 disclosed that it was easier to leave the soiled linen bags at the door of the resident's rooms as she completed the last round of the shift. She revealed staff was not supposed to leave soiled linen on the floor in the hallway but admitted that she did. NA #1 further revealed that she was assigned to the rooms on C Unit where the five, medium sized, open bags of soiled linen were observed. 2. During an observation on 8/28/2018 at 8:47 AM, NA #4 exited a room denoted as Contact Isolation while holding an open bag of soiled linen in her right hand and a disposable isolation gown in her left hand. An interview with NA #4 on 8/28/2018 at 8:50 AM revealed she had just finished giving a bed bath to the resident in the room denoted as Contact Isolation. NA #4 further revealed that she failed to bag all the soiled items while in the room and walked the soiled gown and open bag of soiled linen to the soiled utility room when she should have secured the soiled items before exiting the room. An interview with Nurse #4 on 8/27/2018 at 10:07 AM revealed all staff was expected to wear personal protective equipment in isolation rooms and discard soiled items in the soiled utility room after being secured in the room. 3. During an observation on 8/28/2018 at 10:42 AM, Housekeeper #1 exited a room denoted as Contact Isolation and entered the hallway while	F 880	Preventionist, Treatment Nurse, Director of Nursing, or RN Unit Mangers will conduct observational audits of linen handling technique of 1 Environmental Services employee per day for 5 days a week for one month, 3 days a week for one month, and 1 day a week for one month. Staff Development Coordinator, Infection Preventionist, Treatment Nurse, Director of Nursing, or RN Unit Mangers will conduct unannounced observational audits or return demonstrations of use of personal protective equipment of 1 Nurse, 1 Nurse Aide, and 1 Environmental Services employee per day for 5 days a week for one month, 3 days a week for one month, and 1 day a week for one month. Staff Development Coordinator will discuss audit results at monthly Quality Assurance Performance Improvement meetings. Any trends will be addressed by the Quality Assurance Committee. The Administrator is responsible for this Plan of Correction.	

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F 880	Continued From page 53	F 880		

wearing an isolation gown and gloves. Housekeeper #1 removed the disposable isolation gown and gloves and discarded the soiled items into an open trash receptacle on the hallway. Housekeeper #1 proceeded down the hallway.
An interview with Housekeeper #1 on 8/28/2018 at 10:45 AM revealed she was not aware on how to discard of soiled items used in a Contact Isolation room. Housekeeper #1 further revealed she failed to bag the soiled items in the room. Additionally, Housekeeper #1 revealed she did not wash or sanitize hands after removing personal protective equipment.

An interview on 8/30/2018 at 10:44 AM with the Environmental Services Director revealed all housekeeping staff completed infection control training annually. The Environmental Services Director further revealed she expected all staff to dispose of all soiled items and to sanitize their hands per the infection control policy.

An interview with on 8/30/2018 at 3:59 PM with the Staff Development Coordinator (SDC) revealed all employees complete an annual training on infection control, which includes handling soiled items, standard precautions, transmission precautions, use of personal protective measures, prevention, transmission and monitoring of multi drug resistant organisms and sanitation procedures, every 11 months. The SDC further revealed all soiled items should be discarded immediately in the soiled utility room and never be on the floor. Additionally, the SDC revealed she expected all staff to follow the infection control policy by removing personal protective equipment in the room prior to exiting and to wash or sanitize hands after providing

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F 880	Continued From page 54 care. An interview with the administrator on 8/30/3018 at 5:59 PM revealed he expected all staff to assist with maintaining a clean facility for the residents, not leave any soiled items on the floor and follow the infection control policy	F 880		