| Event ID: | 3H8G11 | Facility ID: 953201 | If continuation sheet Page 1 of 24 |
This REQUIREMENT is not met as evidenced by:

Based on resident and staff interviews, the facility failed to deliver mail to the residents on Saturdays.

Findings include:
An interview was conducted on 11/14/18 at 9:30am with the resident council members. There were 8 residents present. The residents reported they did not receive mail regularly on Saturdays. The residents reported the mail was delivered to the residents on Saturdays only if the activity assistant was present.
An interview was conducted on 11/16/18 at 1:38pm with the Activity Director. She reported mail only was delivered to the residents on Saturdays if her activity assistant worked. She reported her assistant only worked Saturdays if she had not put in 40 hours of work during the week. She reported her assistant was out on medical leave at present. The Activity Director reported usually mail was delivered to the facility on Saturdays and was kept at the nurses’ station until Monday.
An interview was conducted with the administrator on 11/16/18 at 4:40pm. She reported it was her expectation that the residents received mail every Saturday.

A Management Team Meeting was held on 12/6/18 to discuss mail delivery. It was determined there was no set process for delivering mail on Saturdays and therefore Residents did not always receive their mail until Monday. Meeting was held with the Resident Council on 12/13/18 to discuss Saturday mail delivery and newly proposed process. Residents are in agreement with new process.

2. Resident in the facility have the potential to be affected by this alleged practice. A new process was put into place to ensure mail delivery occurs every Saturday. The North Hall Nurse and/or designee is responsible to deliver all resident personal mail every Saturday. Education has been provided to all Nurses regarding this procedure by the Administrator and/or Staff Development Coordinator. Education will be completed by 12/14/18. Any staff member not receiving this education by 12/14/18 will receive education prior to their next scheduled shift.

3. 5 residents will be interviewed each week for the next 4 weeks and then 10 residents a month for the following 2 months to determine if the Saturday mail was delivered. Resident Council members will also be interviewed at each of the next 3 Resident Council meetings to ensure Saturday mail is delivered.
### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** Fisher Park Health and Rehabilitation Center  
1201 Carolina Street  
Greensboro, NC 27401

**Name of Construction:** A. BUILDING  
B. WING

**Provider/Supplier/CLIA Identification Number:** 345014

**Multiple Construction:** C  
**Date Survey Completed:** 11/16/2018

---

#### Summary Statement of Deficiencies

**ID**  | **Prefix**  | **Prefix**  | **Tag**  | **ID**  | **Prefix**  | **Prefix**  | **Tag**  | **Completion Date**
---|---|---|---|---|---|---|---|---
F 576 | Continued From page 2 | F 576 |  
F 600 | Free from Abuse and Neglect  
CFR(s): 483.12(a)(1)  
§483.12 Freedom from Abuse, Neglect, and Exploitation  
The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.  
§483.12(a) The facility must-  
§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;  
This REQUIREMENT is not met as evidenced by: | F 600 | SS=D |  
| | | | | 12/14/18 |
### F 600

**Continued From page 3**

Based on record review and staff interviews, the facility failed to protect 1 out of 3 residents (Resident #267) from verbal abuse. Findings include:

Resident #267 was admitted to the facility on 6/8/18 with diagnoses that included sleep apnea, Chronic Obstructive Pulmonary Disease, and problem related to psychosocial circumstances. A review of Resident #267's most recent MDS (Minimum Data Set) dated 6/15/18 was coded as a 14-day assessment. Active diagnoses included Chronic Obstructive Pulmonary Disease, Sleep apnea, and problems related to psychosocial circumstances.

A review of Resident #267's medical record revealed the resident expired at the facility 7/13/18.

A review of the 24 Hour Initial Allegation Report involving Resident #267 was dated 6/26/18. The report was initiated by the Social Worker. The resident reported that on 6/24/18 a kitchen employee argued with him then stuck up her middle finger at him and told him that she would do "something to his food." The report revealed Resident #267 was upset with the incident but did not experience any physical harm. The 5-day investigation report revealed the dietary aides who witnessed the altercation were disciplined and the employee who argued with the resident was terminated.

An interview was conducted with the dietary manager on 11/16/18 at 12:35pm. She reported Resident #267 told her on 6/26/18 of an incident that occurred on 6/23/18 between him and the cook on the evening shift. The dietary manager reported when she questioned the kitchen staff regarding the incident, two dietary aides admitted witnessing the incident between Resident #267 and the cook but did not notify any one. She

<table>
<thead>
<tr>
<th>ID PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 600</td>
<td></td>
<td>F 600</td>
<td>F 600</td>
<td></td>
<td>1. No action can be completed for Resident #267 as he no longer resides in the facility.</td>
<td>11/16/18</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Residents in the facility have the potential to be affected by this practice. Resident interviews were completed by 12/7/18 with all Residents who scored 8 or above on BIMS, by the Administrator. Interviews included asking questions related to abuse situations, offering examples, while resident in the facility. Observations were completed for other residents who score below 8 BIMS using the CMS Resident Interview and Observation 20050 Form. No other issues related to abuse or abuse that was not reported were identified.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. All staff in the facility will receive education regarding resident abuse reporting, their responsibility to report immediately to their Supervisor any alleged or potential abuse. Staff education will be completed by 12/14/18. Any staff member not receiving this education by 12/14/18 will be required to complete prior to their next scheduled shift. Education will be given by the Staff Development Coordinator and/or Administrator.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Random interviews/observations will continue with 5 resident per week for 4 weeks, then 5 residents a month for 2 months. Interviews/observations will include residents of all cognitive levels.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ID</td>
<td>PREFIX</td>
<td>TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES</td>
<td>ID</td>
<td>PREFIX</td>
<td>TAG</td>
</tr>
<tr>
<td>----</td>
<td>--------</td>
<td>-----</td>
<td>----------------------------------</td>
<td>----</td>
<td>--------</td>
<td>-----</td>
</tr>
<tr>
<td>F 600</td>
<td>Continued From page 4</td>
<td></td>
<td></td>
<td>F 600</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. The Administrator is responsible for implementing and maintaining the acceptable plan of correction to ensure compliance by 12/14/18.

An interview was conducted on 11/16/18 at 2:26pm with Dietary Aide #1. She reported on 6/23/18 around 5:00pm the kitchen staff was told that the residents would eat in their rooms that evening due to the facility being short staffed. She reported Resident #267 was already in the dining room. She stated the cook asked her and the other dietary aide to go tell the resident that he would have to eat in his room. The dietary aide reported Resident #267 got upset easily so she did not want to go tell him. The cook went out and told the resident that all residents were eating dinner in their rooms. The dietary manager reported Resident #267 got upset and started yelling and cursing at the cook. The cook then told the resident not to mess with her because she could not give him what he wanted. The dietary aide stated Resident #267 then cursed at the cook and she yelled the same curse word back to the resident and made an inappropriate hand gesture. The dietary aide stated she did not notify any management personnel because her immediate supervisor was the cook. She reported the dietary manager was not present that evening and she thought that the incident was something that she needed to report face to face. She reported she worked with the cook the next day and there were no problems noted between the cook and any of the residents including Resident #267.

An interview was conducted on 11/16/18 at [2201 CAROLINA STREET GREENSBORO, NC 27401](mailto:2201%20CAROLINA%20STREET%20GREENSBORO,%20NC%2027401)

---

**Event ID:** 3H8G11 **Facility ID:** 953201 **If continuation sheet Page:** 5 of 24
### FISHER PARK HEALTH AND REHABILITATION CENTER

**Address:**
1201 CAROLINA STREET
GREENSBORO, NC 27401

**Provider or Supplier:**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**ID:** 345014

**MULTIPLE CONSTRUCTION**

**DATE SURVEY COMPLETED:**

C
11/16/2018

**NAME OF PROVIDER OR SUPPLIER:**

FISHER PARK HEALTH AND REHABILITATION CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE:**

1201 CAROLINA STREET
GREENSBORO, NC 27401

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 600</td>
<td>Continued From page 5</td>
<td>4:30pm with the administrator. She reported it was her expectation that no staff verbally or physically abuse any of the residents.</td>
<td>F 600</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F 607</td>
<td>Develop/Implement Abuse/Neglect Policies</td>
<td>CFR(s): 483.12(b)(1)-(3)</td>
<td>F 607</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>12/14/18</td>
</tr>
<tr>
<td>SS=D</td>
<td>§483.12(b) The facility must develop and implement written policies and procedures that:</td>
<td>§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and</td>
<td>§483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>F607</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Based on record reviews and staff interviews, the facility failed to follow the abuse policy with the requirement to report abuse within 2 hours of notification of the allegation on 1 out of 3 residents (Resident #267) reviewed for alleged abuse investigations by the facility. The facility staff failed to immediately report abuse to administration on 1 out of 3 residents (Resident #267) reviewed for alleged abuse. The facility also failed to protect residents in 1 out of 3 residents (Resident #267) reviewed for alleged abuse. Findings include:</td>
<td>A review of the facility's &quot;Abuse Investigation and Reporting&quot; policy dated July 2017 revealed in part &quot;An alleged violation of abuse, neglect, or exploitation or mistreatment will be reported immediately but no later than 2 hours if the abuse is reported to the facility staff&quot;.</td>
<td>1.</td>
<td>No action can be completed for Resident #267 as he no longer resides in the facility.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2.</td>
<td>Residents in the facility have the potential to be affected by this practice. An audit of the last 3 months of Abuse Investigations was completed to determine if other resident were not protected or abuse was not reported immediately. No other incidents were identified.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3.</td>
<td>All staff in the facility will receive education regarding resident abuse reporting, their responsibility to report abuse will be reviewed, and all policies and procedures related to resident abuse will be immediately revised and updated.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Event ID:** 3H8G11

**Facility ID:** 953201

**If continuation sheet Page:** 6 of 24
<table>
<thead>
<tr>
<th>EVENT ID</th>
<th>F 607 Continued From page 6</th>
</tr>
</thead>
</table>
| F 607    | alleged violation involved abuse or has resulted in serious bodily injury. "The facility's policy also stated that "any employee witnessed to abuse is to report it to administration immediately." Resident #267 was admitted to the facility on 6/8/18 with diagnoses that included sleep apnea, Chronic Obstructive Pulmonary Disease, and problem related to psychosocial circumstances. A review of Resident #267's most recent MDS (Minimum Data Set) dated 6/15/18 was coded as a 14-day assessment. The resident's cognitive impairment was not completed. A review of Resident #267's medical record revealed the resident expired at the facility 7/13/18. A review of the 24 Hour Initial Allegation Report involving Resident #267 was dated 6/26/18 with no time noted. The report was initiated by the Social Worker. The resident reported that on 6/24/18 a kitchen employee argued with him then stuck up her middle finger at him and told him that she would do "something to his food." The report revealed Resident #267 was upset with the incident but did not experience any physical harm. The 24 Hour Initial Allegation Report fax (facsimile) cover sheet was time stamped as being sent to the state on 6/26/18 at 4:39pm. An interview was conducted with the SW (Social Worker) on 11/16/18 at 12:15pm. She reported she was given the incident on 6/26/18 but doesn't remember what time. The SW reported when she initiated the allegation report she viewed the incident as an argument and sent the report in as a 24-hour report. The SW acknowledged that she put the incorrect date on the 24 hour report, it should have been 6/23/18. The SW reported she realized now that any form of abuse needed to be reported within 2 hours. An interview was conducted with the dietary immediately to their Supervisor any potential abuse situation or alleged abuse and their responsibility to protect the residents from all forms of abuse. Staff education will be completed by 12/14/18. Any staff member not receiving this education by 12/14/18 will need to complete education prior to their next scheduled shift. Education will be given by the Staff Development Coordinator and/or Administrator. 4. Audit will continue for every alleged abuse situation that is investigated. Investigation will be recorded on audit to ensure alleged abuse is reported immediately and appropriate steps are taken to protect residents. Audit will continue for the next 3 months and results will be reported to the Quality Assurance Performance Improvement Meeting monthly by the Administrator. Any issues or trends identified will be addressed by the committee as they arise and the plan will be revised to ensure continued compliance is achieved. 5. The Administrator is responsible for implementing and maintaining an acceptable plan of correction to ensure compliance by 12/14/18.
<table>
<thead>
<tr>
<th>(X4) ID PREFIX</th>
<th>ID PREFIX</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>(X) ID TAG</td>
<td>(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F 607 Continued From page 7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F 609 Reporting of Alleged Violations</td>
<td></td>
<td></td>
<td>12/14/18</td>
</tr>
</tbody>
</table>

F 607 Continued From page 7

Manager on 11/16/18 at 12:35pm. She reported Resident #267 told her on 6/26/18 at 10:00am of an incident that occurred on 6/23/18 between him and the cook on the evening shift. She reported she notified the administrator immediately and was told to notify the SW which she did around 10:30am on 6/26/18. The dietary manager reported when she questioned the kitchen staff regarding the incident, two dietary aides admitted witnessing the incident between Resident #267 and the cook but did not notify any one. She reported she had a meeting with the cook on 6/27/18 as the cook was not working on 6/26/18. The dietary manager reported the cook admitted she lost her temper with Resident #267 and cursed at him. The dietary manager immediately terminated the cook. She reported she did a written counseling with the two dietary aides who witnessed the altercation.

An interview was conducted on 11/16/18 at 4:30pm with the administrator. She reported it was her expectation that any observed or reported abuse, physical or verbal, needed to be reported immediately to management and an Initial Allegation Report be sent to the state within 2 hours.

F 609 Reporting of Alleged Violations

SS=D CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 609</td>
<td></td>
<td>Continued From page 8 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to report allegations of abuse to the North Carolina Division of Health Service Regulations within the 2-hour timeframe on 1 out of 3 (Resident #267) reviewed for abuse allegations. Findings included: Resident #267 was admitted to the facility on 6/8/18 with diagnoses that included sleep apnea, Chronic Obstructive Pulmonary Disease, and problem related to psychosocial circumstances. A review of Resident #267’s most recent MDS (Minimum Data Set) dated 6/15/18 was coded as a 14-day assessment. No cognition impairment was documented. A review of Resident #267's medical record revealed the resident expired at the facility 7/13/18.</td>
</tr>
<tr>
<td>F 609</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. No action can be completed for Resident #267 as he no longer resides in the facility.

2. Residents in the facility have the potential to be affected by this practice. An audit of the last 3 months of Abuse Investigations was completed to determine if other reports to the State Survey Agency were not completed within the 2 hour timeframe. No other incidents were identified.

3. The Administrator and Director of Nursing received education regarding resident abuse reporting within the 2 hour timeframe.
F 609 Continued From page 9
A review of the 24 Hour Initial Allegation Report involving Resident #267 was dated 6/26/18. The report was initiated by the Social Worker, but she reported she doesn’t remember what time the dietary manager informed her of the incident. The resident reported that on 6/24/18 a kitchen employee argued with him then stuck up her middle finger at him and told him that she would do "something to his food." The report revealed Resident #267 was upset with the incident but did not experience any physical harm. The 24 Hour Initial Allegation Report fax (facsimile) cover sheet was time stamped as being sent to the state on 6/26/18 at 4:39pm.

An interview was conducted with the SW (Social Worker) on 11/16/18 at 12:15pm. She reported she was given the incident on 6/26/18 but doesn’t remember what time. She stated she knew it was in the morning of 6/26/18. The SW reported when she initiated the allegation report she viewed the incident as an argument and sent the report in as a 24-hour report. The SW reported she realized now that any form of abuse needed to be reported within 2 hours.

An interview was conducted with the dietary manager on 11/16/18 at 12:35pm. She reported Resident #267 told her on 6/26/18 at 10:00am of an incident that occurred on 6/23/18 between him and the cook on the evening shift. She reported she immediately reported the incident to the administrator and was told to notify the SW (Social Worker). The dietary manager reported she notified the SW around 10:30am. The dietary manager reported when she questioned the kitchen staff regarding the incident, two dietary aides admitted witnessing the incident between Resident #267 and the cook but did not notify any one. The dietary aides were given written counseling regarding notifying abuse allegations.

4. Audit will continue for every alleged abuse situation that is reported to the State Survey Agency for the next 3 months to ensure the 2 hour timeframe is adhered to. Results of these audits will be reported at the Quality Assurance Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the committee as they arise and the plan will be revised to ensure continued compliance.

5. The Administrator is responsible for implementing and maintaining an acceptable plan of correction to ensure compliance by 12/14/18.
An interview was conducted on 11/16/18 at 2:26pm with Dietary Aide #1. She reported on 6/23/18 around 5:00pm the kitchen staff was told that the residents would eat in their rooms that evening due to the facility being short staffed. She reported Resident #267 was already in the dining room. She stated the cook asked her and the other dietary aide to go tell the resident that he would have to eat in his room. The dietary aide reported Resident #267 got upset easily so she did not want to go tell him. The cook went out and told the resident that all residents were eating dinner in their rooms. The dietary manager reported Resident #267 got upset and started yelling and cussing at the cook. The cook then told the resident not to mess with her because she could not give him what he wanted. The dietary aide stated Resident #267 then cursed at the cook and she yelled the same curse word back to the resident and made an inappropriate hand gesture. The dietary aide stated she did not notify any management personnel because her immediate supervisor was the cook. She reported the dietary manager was not present that evening and she thought that the incident was something that she needed to report face to face. She reported she worked with the cook the next day and there were no problems noted between the cook and any of the residents including Resident #267. She reported she had not seen the dietary manager to report the incident before the resident reported it to the dietary manager.

An interview was conducted on 11/16/18 at 4:30pm with the administrator. She reported it was her expectation that all allegations of abuse be reported immediately, and the Initial Allegation Report be sent to the state within 2 hours.
### Statement of Deficiencies and Plan of Correction

**Fisher Park Health and Rehabilitation Center**

**Address:**
1201 Carolina Street, Greensboro, NC 27401

**Survey Date Completed:**
11/16/2018

#### Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 623</td>
<td>SS=D</td>
<td></td>
<td>Continued From page 11</td>
</tr>
</tbody>
</table>

§483.15(c)(3) Notice before transfer.
Before a facility transfers or discharges a resident, the facility must-

1. Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
2. Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
3. Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.

1. Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
2. Notice must be made as soon as practicable before transfer or discharge when-
   - (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
   - (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(B) of this section;
   - (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
   - (D) An immediate transfer or discharge is required by the resident's urgent medical needs,
F 623 Continued From page 12
under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30
days.

§483.15(c)(5) Contents of the notice. The written
notice specified in paragraph (c)(3) of this section
must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is
transferred or discharged;
(iv) A statement of the resident’s appeal rights,
including the name, address (mailing and email),
and telephone number of the entity which
receives such requests; and information on how
to obtain an appeal form and assistance in
completing the form and submitting the appeal
hearing request;
(v) The name, address (mailing and email) and
telephone number of the Office of the State
Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual
and developmental disabilities or related
disabilities, the mailing and email address and
telephone number of the agency responsible for
the protection and advocacy of individuals with
developmental disabilities established under Part
C of the Developmental Disabilities Assistance
and Bill of Rights Act of 2000 (Pub. L. 106-402,
codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental
disorder or related disabilities, the mailing and
email address and telephone number of the
agency responsible for the protection and
advocacy of individuals with a mental disorder
established under the Protection and Advocacy
for Mentally Ill Individuals Act.
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**NAME OF PROVIDER OR SUPPLIER**
FISHER PARK HEALTH AND REHABILITATION CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**
1201 CAROLINA STREET
GREENSBORO, NC 27401

---

**SUMMARY STATEMENT OF DEFICIENCIES**
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 623</td>
<td>F 623</td>
<td><strong>§483.15(c)(6) Changes to the notice.</strong> If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>§483.15(c)(8) Notice in advance of facility closure</strong> In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at §483.70(l). This REQUIREMENT is not met as evidenced by:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Based on record review and staff interviews, the facility failed to notify the Ombudsman in writing when 1 of 3 residents (Resident #24) transferred to the hospital.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Findings include: Resident #24 was admitted to the facility on 1/10/13 with diagnoses that included cerebral infarction, Diabetes Mellitus, and hemiplegia. A review of Resident #24's most recent MDS (Minimum Data Set) was coded as a quarterly assessment and dated 10/6/18. The resident was coded with no cognitive impairment. Active diagnoses included hypertension, diabetes mellitus, and cerebrovascular accident. A review of Resident #24's care plan dated 10/6/18 revealed the resident was care planned for constipation. A review of Resident #24's medical record revealed the resident was hospitalized 11/8/18-11/9/18 with diagnoses of abdominal</td>
<td></td>
</tr>
</tbody>
</table>

---

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><strong>F623</strong> 1. The Ombudsman was notified of the failure to notify her of Resident #24 being transferred to the hospital.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. The Social Worker was educated by the Administrator on 12/11/18 of the requirement to notify the Ombudsman of resident transfers to the hospital. She was provided a log to maintain and send to Ombudsman by the 10th of each month, as per agreement with Ombudsman.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. The transfer/discharge log was completed for all residents who experienced a transfer to the hospital for the last 3 months. Completed log was faxed to the Ombudsman on 12/9/18, she</td>
<td></td>
</tr>
</tbody>
</table>
**NAME OF PROVIDER OR SUPPLIER**

**FISHER PARK HEALTH AND REHABILITATION CENTER**

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 623</td>
<td>Continued From page 14</td>
<td>F 623</td>
<td>was notified that the practice would continue on a monthly basis. The Social Worker is responsible for notification and producing fax confirmation or email confirmation that information was sent by the 10th of each month. The Ombudsman will also continue to be notified of all discharges to home or another level of care as soon as is practicable before transfer or discharge. The Social Worker is also responsible for notifications to the Ombudsman of discharges to home or another level of care.</td>
<td>12/14/18</td>
</tr>
<tr>
<td>F 641</td>
<td>Accuracy of Assessments</td>
<td>F 641</td>
<td>$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 observations, record review, and staff interviews, the facility failed to accurately code the MDS (Minimum Data Set) for 1 out of 5 residents (Resident #58) reviewed for unnecessary medications and 1 out of 6 residents</td>
<td>12/14/18</td>
</tr>
</tbody>
</table>
(Resident #26) reviewed for nutrition.

Findings included:

1. Resident #58 admitted to the facility on 6/17/18 with diabetes mellitus, major depressive disorder, Chronic Obstructive Pulmonary Disease, neuromuscular dysfunction bladder, and Methicillin Resistant Staphylococcus Aureus right foot.

A review of Resident #58's most recent MDS (Minimum Data Set) dated 11/14/18 was coded as a significant change assessment. The resident was coded as cognitively intact. Active diagnoses included heart failure, neurogenic bladder, diabetes, depression, and chronic pain.

A review of Resident #58's medical record revealed a physician's order dated 10/23/18 that read Amitriptyline 10mg (milligrams) at bedtime for insomnia.

An interview was conducted on 11/16/18 at 10:24am with the MDS Coordinator. She reported it was her responsibility to correctly code all MDS assessments. She reported Resident #58 should have had the diagnosis of insomnia coded on his significant change MDS assessment.

An interview was conducted on 11/16/18 at 5:00pm with the administrator. She reported it was her expectation that the MDS coordinator correctly code all MDS assessments.

F 641 Continued From page 15

2. Resident #26 was admitted to the facility on 10/30/12 and diagnoses included end stage renal for Residents #58 and #26. Resident #58 had a modification of Section I completed to reflect accurate medical diagnosis for Assessment Reference Date 10/24/18. Resident #26 had a modification of Section K completed to reflect accurate coding of therapeutic diet for Assessment Reference Date 10/19/18.

2. The MDS Coordinator will complete an audit of current residents receiving an Omnibus Budget Reconciliation Act Assessment during November to verify accurate coding of Sections I and K of the Minimum Data Set per the Resident Assessment Instrument Manual guidelines. If needed, modifications will be completed by the MDS Coordinator per the RAI Manual guidelines.

3. The District Director Care Manager will provide education to the Interdisciplinary Team members who participate in MDS coding of Sections I and K related to accurate coding of MDS according to the RAI Manual on 12/7/18. The MDS Coordinator will randomly audit 5 completed MDSs weekly for 4 weeks and then 5 random MDSs monthly for an additional 2 months to verify accurate coding of Sections I and K of the MDS. One to one education will be provided if opportunities for corrections are identified as a result of these audits. Modifications to the MDS will be completed as needed.

4. The results of these audits will be presented by the Director of Care Management monthly for 3 months at the
### F 641

**Continued From page 16**

disease, diabetes and congestive heart failure.

A quarterly minimum data set (MDS) dated 10/9/18 for Resident #26 did not identify that she received a therapeutic diet.

Review of the November 2018 physician orders for Resident #26 revealed an order for a consistent carbohydrate, no added salt, 1200 milliliter (ml) fluid restriction. The diet had an initiation order date of 7/30/18.

An interview on 11/15/18 at 2:15 pm with the MDS Nurse revealed Section K of the 10/9/18 MDS for Resident #26 should have been coded for a therapeutic diet.

An interview on 11/16/18 at 3:29 pm with the Director of Nursing revealed it was her expectation that MDS ' s were coded correctly to reflect the resident ' s physician ' s orders.

An interview on 11/16/18 at 2:15 pm with the Director of Nursing revealed it was her expectation that MDS ' s were coded correctly to reflect the resident ' s physician ' s orders.

F 641

**Quality Assurance Performance Improvement meeting. The committee will make recommendations or changes as indicated.**

5. The Director of Care Management is responsible for the plan to correct and ensuring compliance by 12/14/18.

### F 677

**ADL Care Provided for Dependent Residents**

CFR(s): 483.24(a)(2)

§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;

This REQUIREMENT is not met as evidenced by:

Based on observations, record review, resident and staff interviews the facility failed to provide a bath for a resident that was dependent for Activities of Daily Living (ADL’s). This was evident for 1 of 3 residents that were reviewed for ADL’s (Resident #6).

Findings Included:

F 677

1. The facility failed to provide a bath for a resident that was dependent for Activities of Daily Living. The Director of Nursing on 11/19/18 completed an interview with resident #6 regarding the alleged deficient practice of providing care needs including
Resident #6 was admitted to the facility on 3/6/09 and diagnoses included diabetes, chronic kidney disease, agoraphobia with panic disorder, depressive disorder and low back pain.

A quarterly minimum data set (MDS) dated 8/23/18 for Resident #6 identified she was totally dependent on staff for bathing, required extensive one-person assist with personal hygiene, was always incontinent of bowel and bladder and her cognition was intact.

A care plan dated 9/11/18 for Resident #6 stated she had an ADL self-care performance deficit related to impaired balance and limited mobility. An intervention included for staff to provide extensive assistance with bathing, toileting and personal hygiene as needed.

An observation and interview with Resident #6 on 11/13/18 at 11:41 am revealed the resident was awake and lying in bed. There was a very strong offensive odor present. Resident #6 stated she hadn’t had a bed bath since Sunday (11/11/18). She stated she didn’t like to take showers, but she did want a bed bath daily. The resident stated she had a yeast infection and denied needing to have her brief changed.

An observation and interview on 11/13/18 at 1:15 pm with Resident #6 revealed she was lying in bed eating her lunch. A strong offensive odor remained present. The resident stated she had still not received her bath.

An interview on 11/14/18 at 3:23 pm with NA #1 revealed she was familiar with the Resident #6, but she wasn’t on her assignment today. She

bathing, being met and addressed appropriately. Nursing Assistant #4 was re-educated on 12/7/18, and Nursing Assistant #3 was re-educated on 11/19/18 by the Director of Nursing. Both were re-educated that residents who are unable to carry out activities of daily living including bathing receive the necessary services to maintain good grooming and personal hygiene.

2. Residents in the facility have the potential to be affected by the alleged deficient practice. Interviews and observations were completed by the Director of Nursing regarding their care needs (bathing) being met, this was completed by 11/20/18. Any concerns identified were addressed.

3. Re-education was completed for Nursing Assistants by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Coordinator regarding the provision of a bath to residents who are unable to carry out activities of daily living receive the necessary services to maintain good grooming and personal hygiene. This re-education will be completed by 12/14/18. Any remaining Nursing Assistants will have re-education completed prior to working their first scheduled shift after this date. This education will be provided upon hire for all Nursing Assistants.

4. Audit observation of 5 resident baths will be conducted weekly for 4 weeks then...
## Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:** 345014

**Date Survey Completed:** 11/16/2018

### F 677

**Summary Statement of Deficiencies**

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Description</th>
</tr>
</thead>
</table>
| F 677 | Continued From page 18 | | stated the resident was oriented and could make her needs known. She added the resident would turn on her call light when she needed something. NA #1 stated the resident received bed baths on 1st shift and she typically worked on 2nd shift. An interview on 11/14/18 at 3:31 pm with Nurse #1 revealed Resident #6 was scheduled to have showers on Wednesdays and Saturdays on 1st shift. She stated the NAs were supposed to document if the resident refused to be bathed and report it to the nurse. Review of the shower book, provided by Nurse #1, did not contain any records for the month of November for Resident #6. An observation on 11/14/18 at 8:30 pm of Resident #6 revealed she was lying in bed and there continued to be a strong offensive odor present. An interview on 11/15/18 at 9:18 am with Resident #6 revealed she had not received a bath yesterday (11/14/18), but her Nursing Assistant (NA) was going to give her a bed bath today. An observation on 11/15/18 at 10:04 am was conducted of bathing and personal hygiene for Resident #6. A full bed bath was performed. The resident’s genital area appeared very red. An interview on 11/15/18 at 11:03 am with NA #2, who had completed the bath for Resident #6, revealed the resident required total care, was usually reliable and did not refuse care. Review of the staff schedule, provided by the |}

**Provider’s Plan of Correction**

3 baths weekly for 2 months. All data will be summarized and presented to the facility Quality Assurance Performance Improvement committee for 3 months by the Director of Nursing. Any issues or trends identified will be addressed by the Committee as they arise and the plan will be revised to ensure continued compliance.

5. The Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction and ensure continued compliance by 12/14/18.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**
FISHER PARK HEALTH AND REHABILITATION CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**
1201 CAROLINA STREET
GREENSBORO, NC 27401

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 677</td>
<td>Continued From page 19</td>
<td>F 677</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F 690</td>
<td>SS=D</td>
<td>Bowel/Bladder Incontinence, Catheter, UTI</td>
<td>F 690</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SUMMARY STATEMENT OF DEFICIENCIES**
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

**F 677**
Director of Nursing (DON), identified NA #3 was assigned to Resident #6 on first shift for 11/12/18 and NA #4 was assigned to Resident #6 on first shift for 11/13/18.

A phone interview with NA #3 was attempted on 11/15/18 at 12:50 pm. NA #3 did not answer the phone and a message could not be left due to the voice mail box being full.

An interview on 11/15/18 at 12:58 pm with the Administrator revealed NA #4 was currently suspended for not providing resident care. She stated she was investigating an incident that had been reported by another resident that NA #4 had not provided required care. The Administrator stated she would add Resident #6 to the investigation since NA #4 had also been assigned to her.

An interview on 11/16/18 at 3:26 pm with the DON revealed it was her expectation that residents were clean, odor free and bathed daily.

**F 690**
**SS=D**
Bowel/Bladder Incontinence, Catheter, UTI

CFR(s): 483.25(e)(1)-(3)

§483.25(e) Incontinence.
§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.

§483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-
F 690 Continued From page 20

(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;
(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and
(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.

This REQUIREMENT is not met as evidenced by:

Based on observation, record reviews, staff interviews and Physician Assistant interview the facility failed to insert the correct size indwelling urinary catheter as ordered by the physician for one of two residents reviewed for urinary catheters (Resident #39).

Findings included:

Resident #39 was admitted to the facility on 4/19/2016 with diagnoses of pressure ulcer to sacrum, diabetes, dementia, cognitive communication deficit and bilateral amputations.

A review of the quarterly Minimum Data Set

F 690

1. An assessment was completed by the Director of Nursing on 11/16/18 and found indwelling foley catheter to be patient and functioning properly. The MD was called and catheter order changed to reflect the current catheter size for Resident #29. Nurse #6 was educated by the Director of Nursing on 11/16/18 to insert the correct size indwelling urinary catheter as ordered by the MD.

2. All other residents with indwelling urinary catheters have the potential to be
### Statement of Deficiencies and Plan of Correction

#### Provider/Supplier/CLIA Identification Number:
345014

#### Date Survey Completed
11/16/2018

#### Name of Provider or Supplier
Fisher Park Health and Rehabilitation Center

#### Street Address, City, State, Zip Code
1201 Carolina Street
Greensboro, NC 27401

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Summary Statement of Deficiencies (Each deficiency must be preceded by full regulatory or LSC identifying information)</th>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Provider's Plan of Correction (Each corrective action should be cross-referenced to the appropriate deficiency)</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 690</td>
<td>Continued From page 21</td>
<td>(MDS) dated October 17, 2018 revealed Resident #39 had an indwelling urinary catheter, required extensive to total dependence for activities of daily living (ADLs) and had moderately impaired cognition. Review of a progress note dated June 15, 2018, revealed Resident #39 had pulled her indwelling catheter out and was found sitting on her bed. A #16 French catheter was re-inserted. Review of a progress note dated August 14, 2018 revealed Resident #39 had a #24 French catheter inserted. Review of a physician ’ s order dated September 13, 2018 for Resident #39 stated may change catheter #16 French with a 10-cubic centimeter (cc) balloon as needed every 24 hours for leaking, malfunction or dislodgement. Review of Resident #39 ’ s care plan dated November 14, 2018 revealed she was at risk for urinary tract infections. Interventions included catheter care to be done every shift as needed, position catheter bag and tubing below the level of the bladder. During an interview with Nurse #6 on November 15, 2018 at 1:00 pm revealed the physician had ordered a #16 French catheter for Resident #39. During an interview with the Physician Assistant on November 15, 2018 at 1:00pm revealed if a resident had a #16 French catheter replaced with a #24 French catheter their urethra would be stretched and could potentially cause some organ damage.</td>
<td>F 690</td>
<td>affected by the alleged deficient practice. No other concerns were identified.</td>
<td>3. Licensed Nurses received education by the Director of Nursing, Staff Development Coordinator and Assistant Director of Nursing to reconcile correct size indwelling urinary catheter with MD order prior to insertion. Education was completed by 12/14/18. Any remaining PRN Nurses will receive education prior to next scheduled shift and all newly hired Nurses will receive education during orientation. 4. The Staff Development Coordinator, Director of Nursing and Assistant Director of Nursing will complete indwelling urinary catheter audits to ensure correct size of indwelling catheter as ordered by the MD, monthly for 3 months. If any concerns with correct size of indwelling urinary catheter, the Director of Nursing will be notified immediately. All data will be summarized and presented to the facility Quality Assurance Performance Improvement Committee monthly for 3 months by the Director of Nursing. Any issues and trends identified will be addressed by the Committee as they arise and the plan will be revised to ensure continued compliance. 5. The Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction and continued compliance by 12/14/18.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Statement of Deficiencies and Plan of Correction

**Fisher Park Health and Rehabilitation Center**

**Street Address, City, State, Zip Code:**
1201 Carolina Street, Greensboro, NC 27401

**Provider/Supplier/CLIA Identification Number:**
345014

**Date Survey Completed:**
11/16/2018

<table>
<thead>
<tr>
<th>ID Prefix</th>
<th>Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>ID Prefix</th>
<th>Tag</th>
<th>Provider's Plan of Correction (Each Corrective Action Should be Cross-Referenced to the Appropriate Deficiency)</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 690</td>
<td></td>
<td>Continued From page 22</td>
<td>F 690</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>An observation of Resident #39 on November 15, 2018, at 1:40pm revealed there was a #24 French catheter present.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Several phone calls were made to staff that were identified as inserting the #24 French catheter in Resident #39 and no return calls were received.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>During an interview with the Director of Nurses on November 16, 2018 at 3:10 pm she stated it was her expectation that catheters are placed according to the size ordered by the physician.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F 867</td>
<td>SS=D</td>
<td>QAPI/QAA Improvement Activities</td>
<td>F 867</td>
<td></td>
<td></td>
<td>12/14/18</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CFR(s): 483.75(g)(2)(ii)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>§483.75(g) Quality assessment and assurance.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>§483.75(g)(2) The quality assessment and assurance committee must:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>This REQUIREMENT is not met as evidenced by:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Based on staff interviews and record review, the facility’s Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor interventions that the committee put into place following the annual recertification survey on 1/26/18. This was for 1 recited deficiency in the area of: Accuracy of Assessments (F641).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Findings include:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>This tag is cross referenced to:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>F641 Accuracy of Assessments: Based on observations, record review, and staff interviews, the facility failed to accurately code the MDS (Minimum Data Set) for 1 out of 5 residents (Resident #58) reviewed for unnecessary</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
F 867 Continued From page 23
medications and 1 out of 6 residents (Resident #) reviewed for nutrition.
During the recertification survey dated 1/26/18, the facility was cited for F641 for failing to accurately code the opioid medications on 1 out of 5 residents (Resident #74) reviewed for unnecessary medications, to accurately code the weight changes on 1 out of 5 residents (Resident #36) reviewed for weight changes, to accurately code falls involving 1 out of 1 resident (Resident #52) reviewed for falls, and to accurately code oxygen on 1 out of 1 residents (Resident #48) reviewed for respiratory care.
During the recertification survey dated 1/26/18, the facility was cited for F867 for the QAA (Quality Assessment and Assurance Committee) failing to maintain implemented procedures and monitor interventions that the committee put into place following the 1/26/18 recertification survey. During the current annual recertification survey dated 11/16/18, the facility failed to maintain implemented procedures and monitor interventions that the committee put into place following the 1/26/18 annual recertification survey.

An interview was conducted with the Administrator on 11/16/18 at 5:00pm. She reported it was her expectation that the QAA committee would implement and monitor interventions put into place.

F 867
2. The Committee determined that random audits of MDS accuracy will continue monthly for 3 months. If accuracy is not confirmed, Interdisciplinary Team members responsible will be addressed one to one and audits will be extended beyond the 3 months until accuracy is achieved. Any inaccurate MDS will be corrected and transmitted following correction process.

3. Audits will be brought to the monthly Quality Assurance Performance Improvement Committee meeting for review and recommendations if necessary. Any inaccuracy that is found will be immediately addressed with the Interdisciplinary Team member responsible and correction made. The District Clinical Director will review the facility Quality Assurance Performance Improvement Committee meeting minutes monthly for 3 months to ensure accuracy is achieved and make recommendations if necessary.

4. The Administrator is responsible for implementing the plan of correction, Chairing the Quality Assurance Performance Improvement Committee and ensuring the plan of correction is complete and sustained so that compliance is achieved.