

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345448</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/09/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>MAPLE GROVE HEALTH AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406</b>	
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E 000	Initial Comments	E 000		
F 641 SS=E	<p>Accuracy of Assessments CFR(s): 483.20(g)</p> <p>§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 and staff interviews the facility failed to ensure the accuracy of the Minimum Data Set (MDS) assessments in the areas of activities of daily living, medications, behaviors and pressure ulcers for 5 of 20 sampled residents whose MDS assessments were reviewed. (Resident #54, Resident #81, Resident #60, Resident #95 and Resident #86).</p> <p>Findings Included:</p> <p>1. Resident #54 was admitted to the facility on 8/27/13 with diagnoses that included Non-Alzheimer's dementia, End Stage Renal Disease, and Congestive Heart Failure.</p> <p>Resident #54's MDS (Minimum Data Set) dated 12/25/18 was coded as a quarterly assessment. Resident #54 was coded with no cognitive impairment. The MDS coded the resident with active diagnoses that included heart failure, Non-Alzheimer's dementia, and End Stage Renal Disease. Resident #54 was coded functionally as</p>	F 641	<p>F641</p> <p>Maple Grove Health and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and is order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.</p> <p>Maple Grove Health and Rehabilitation response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Maple Grove Health and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal</p>	5/31/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/31/2019

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

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F 641	<p>Continued From page 1 independent with set up help only.</p> <p>Resident #54's most recent quarterly MDS dated 3/25/19 revealed the resident had no cognitive impairment. Resident #54's functional status was coded as the resident needing one-person assistance and supervision for bed mobility, transfers, walking, toileting, eating, bathing, dressing, and personal hygiene.</p> <p>Resident #54's care plan dated 3/26/19 revealed the resident was care planned that the resident was independent in all ADLs (Activities of Daily Living).</p> <p>An interview was conducted with Nurse #13 on 5/9/19 at 11:00am. She reported Resident #54 was independent with all ADLs and had not had a decline.</p> <p>An interview was conducted with Resident #54 on 5/9/19 at 12:50pm. She reported she had always performed own ADLs without any assistance. She reported she had not had any decline recently.</p> <p>An interview was conducted with the MDS nurse on 5/9/19 at 1:20pm. She reported Resident #54 had not had a decline in ADLs, but she had inaccurately coded the most current MDS.</p> <p>2. Resident #81 was admitted to the facility on 12/31/18 with diagnoses that included chronic kidney disease, coronary artery disease, and neoplasm of the colon.</p> <p>Resident #81's most recent MDS dated 4/5/19 was coded as a quarterly assessment. The resident was coded as minimally cognitive impaired. Active diagnoses included chronic</p>	F 641	<p>appeal procedure and/ or any other administrative or legal proceeding.</p> <p>Resident #60 MDS assessment 5/21/2019 was modified to accurately reflect residents recorded behaviors in Point Click Care by the Nursing Assistants. The Minimum Data Set Coordinator modified the assessment which was accepted by the National Repository on 5/24/2019</p> <p>Resident #95 MDS assessment 5/21/2019 was modified to accurately reflect residents recorded behaviors in Point Click Care by the Nursing Assistants. The Minimum Data Set Coordinator modified the assessment which was accepted by the National Repository on 5/24/2019.</p> <p>Resident # 86 MDS assessment was modified on 5/28/2019 to accurately reflect resident's pressure ulcer on the sacral as well as the left inner ankle. The Minimum Data Set Coordinator modified the assessment in section M which was transmitted to the National Repository on 5/28/2019.</p> <p>Resident # 54 MDS assessment was modified on 5/29/2019 to accurately reflect resident's independence with ADLs. The Minimum Data Set Coordinator modified the assessment in which was transmitted to the National Repository on 5/29/2019.</p> <p>Resident # 81 MDS assessment dated 4/5/19 was modified to accurately reflect resident # 81 was without opioid's usage during that 7 day look back period. The MDS was modified by the Minimum Data Set Coordinator and successfully transmitted to the National Repository on</p>		

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F 641	<p>Continued From page 2</p> <p>kidney disease, coronary artery disease, and neoplasm of the colon/rectum. Under the medication section of Resident #81's MDS it was documented that the resident received an opioid 7 out of 7 days in the 7 day look back period. It was also documented that Resident #81 received an antibiotic 5 out of 7 days in the 7 day look back period.</p> <p>Resident #81's medical record revealed a physician's order dated 4/1/19 that read 'Rocephin 1 gram with Lidocaine Intramuscular daily for 7 days for Urinary Tract Infection.'</p> <p>Resident #81's Medication Administration Record revealed the resident was ordered Percocet 5-325mg every 6 hours as needed for pain but did not receive it during the 7 day look back for the quarterly MDS.</p> <p>An interview was conducted on 5/8/19 at 1:10pm with the MDS nurse. She reported she mistakenly coded Resident #81's medication section with the resident receiving an opioid 7 out of 7 days. She also reported she should have coded the Urinary Tract Infection under the active diagnosis section of Resident #81's 4/5/19's quarterly MDS.</p> <p>An interview was conducted on 5/9/19 at 1:30pm with the Administrator. She reported it was the responsibility of the MDS nurse to accurately code all MDS assessments. She reported it was her expectation that all MDS assessments were coded accurately.</p> <p>3. Resident # 60 was admitted to facility 2/27/18 with cumulative diagnoses which included mood disorder, anxiety disorder and major depressive disorder.</p>	F 641	<p>5/17/2019 by The Minimum Data Set Coordinator. The diagnosis to reflect the UTI as an active diagnosis was updated by the Medical Records Supervisor on 5/19/2019.</p> <p>On 5/21/2019 an audit was initiated by the Minimum Data Coordinator to ensure all residents in the past 30 days had an accurate assessment of recorded behaviors. The audit was completed on 5/24/2019 with any identified resident with a modification and an accepted assessment at the National Repository. On 5/28/2019 an audit of the last 30 days of transmitted assessment was initiated by the Minimum Data Set Coordinator to ensure accuracy of opioid usage coded on the MDS assessments. The audit was completed on 5/29/2019 with any identified resident with a modification, and a transmitted assessment to the National Repository. On 5/28/2019 an audit was initiated by the Minimum Data Set Coordinator to identify residents with pressure ulcers. The audit included residents with an assessment within the last 30 days. Any residents that required modification at the completion of the audit on 5/28/2019 were successful transmitted to the National Repository. On 5/28/2019 an audit was initiated by the Principle Long-Term Care Corporate Minimum Data Set Nurse to ensure accuracy of resident s coded with a decline in ADLs on the MDS assessments. The audit was completed on 5/29/2019 without any identified resident requiring a modification.</p>		

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F 641	<p>Continued From page 3</p> <p>Record review of Resident #60 ' s behavior documentation from "Point of Care" form used by the Nursing Assistant (NA) indicated the resident exhibited the following behaviors:</p> <p>On 3/23/19 and 3/24/19 Resident #60 was pacing and yelling, screaming, "and/or cursing." On 3/25/19 Resident #60 was pacing. On 3/27/19 Resident #60 was wandering. On 3/28/19 Resident #60 was wandering, yelling, screaming, "and/or cursing."</p> <p>Review of Quarterly Minimum Data Set (MDS) assessment dated 3/29/19 revealed "behavioral symptoms" were coded as not exhibited.</p> <p>Interview on 05/09/19 at 10:02 AM with the MDS coordinator revealed she used the nurses ' notes for information about behaviors and was unaware of the NA "Point of Care" documentation for behaviors. The MDS coordinator confirmed Resident #60 ' s 3/29/19 MDS did not accurately assess the resident ' s behavioral symptoms.</p> <p>Interview with the administrator on 05/09/19 at 10:29 AM revealed she expected the MDS coordinator to review all associated documents for coding not just the nursing notes.</p> <p>4. Resident #95 was admitted to facility on 2/6/18 with cumulative diagnoses which included vascular dementia without behavioral disturbance and cognitive communication deficit and major depressive disorder.</p> <p>Record review of Resident #95 ' s behavior documentation from "Point of Care" form used by the Nursing Assistant (NA) indicated the resident</p>	F 641	<p>On 5/29/2019 the MDS coordinator was in-serviced on accuracy of MDS assessments inclusive of coding opioid usage, ADL□s dependency, behaviors, and wounds by the Principle Long Term Care Regional MDS Consultant.Any newly hired MDS coordinators will be in-serviced during orientation.</p> <p>On 5/16/2019 an in service was conducted by the Medical Record Supervisor on the process to send notification to Medical Record Supervisor of active acute diagnosis.</p> <p>An in service was provided to the Minimum Data Set Coordinator by the administrator on updated the diagnosis during daily IDT Cardinal Meeting to ensure al residents have an active diagnosis.</p> <p>All newly hired Minimum data Set coordinators will receive the same in service at orientation.</p> <p>An assigned Registered Nurse will audit 3 of MDS assessments complete and submitted to the National Repository weekly x 4 weeks then 2 weekly x 8 weeks to ensure assessments were submitted accurately in behaviors, ADL□s, opioid usage and wounds . This audit will be documented on the MDS audit tool.</p> <p>Medical records supervisor to audit weekly X12 weeks utilizing the Diagnosis Communication Form. The audit will be to</p>	

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F 641	<p>Continued From page 4</p> <p>exhibited the following behaviors:</p> <p>On 4/18/19 Resident #95 was yelling, screaming, cursing, pacing, resisted activities of daily living, anxious, with clear threats of violence towards others.</p> <p>On 4/20/19 Resident #95 was yelling, screaming, "and/or cursing. "</p> <p>On 4/21/19 Resident #95 was anxious.</p> <p>On 4/22/19 Resident #95 attempted to exit the facility unsupervised and hit others.</p> <p>On 4/23/19 Resident #95 was yelling, screaming, "and/or cursing." In addition, he swung at others and was anxious.</p> <p>On 4/24/19 Resident #95 was yelling, screaming, "and/or cursing."</p> <p>Review of Quarterly Minimum Data Set (MDS) dated 4/24/19 revealed "behavioral symptoms" were coded as not exhibited.</p> <p>Interview on 05/09/19 at 10:02 AM with the MDS coordinator revealed she used the nurses ' notes for information about behaviors and was unaware of the NA "Point of Care" documentation for behaviors. The MDS coordinator confirmed Resident #95 ' s 4/24/19 MDS did not accurately assess the resident ' s behavioral symptoms.</p> <p>Interview with the administrator on 05/09/19 at 10:29 AM revealed she expected the MDS coordinator to review all associated documents for coding not just the nursing notes.</p> <p>5. Resident #86 was admitted to the facility on 4/17/18 and diagnoses included pressure ulcer of the sacrum.</p> <p>Review of a wound ulcer assessment dated</p>	F 641	<p>ensure active diagnosis for residents with urinary tract infection.</p> <p>The monthly QAPI committee consisting of Administrator, Director of Nursing, Staff Facilitator, Assistant Director of Nursing, Dietary manager, Activities directors, and Social workers. Will review the results of the audit tools monthly for 3 months and as needed for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QAPI committee and to the quarterly QAPI committee consisting of Medical Directors, Pharmacy Consultant, Administrator, Director of Nursing, Staff Facilitator, and Assistant Director of Nursing, Dietary Manager, Activities Directors, and Social Workers for further recommendations and oversight.</p> <p>The MDS coordinator is responsible for implementing an acceptable plan of correction.</p>		

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F 641	Continued From page 5 4/9/19 for Resident #86 revealed a Stage 4 pressure ulcer to the sacrum and a Stage 2 pressure ulcer to the left inner ankle.  Review of an annual MDS dated 4/17/19 for Resident #86 revealed section M0100, section A was answered no; the resident did not have any current pressure ulcers. Section M0210 identified the resident had one Stage 4 and one Stage 2 unhealed pressure ulcers.  An interview on 5/9/19 at 11:55 am with the MDS Nurse revealed she had completed the annual MDS dated 4/17/19 for Resident #86. She stated she had coded section M0100, section A incorrectly because the resident did have 2 unhealed pressure ulcers.  An interview on 5/9/19 at 1:30 pm with the Administrator revealed it was her expectation that the MDS was coded correctly.	F 641			
F 689 SS=G	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 record review, physician and staff interviews the facility failed to transfer a resident from the bed to the chair using 2 staff members and a mechanical lift according to her plan of	F 689	F-689  Resident # 38 interventions completed as stated in 2567.	5/31/19	

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F 689	<p>Continued From page 6</p> <p>care which resulted in a fall and a fracture of her right femur. This was evident for 1 of 3 residents reviewed for accidents (Resident #38).</p> <p>Findings Included:</p> <p>Resident #38 was admitted to the facility 6/6/13 and diagnoses included chronic obstructive pulmonary disease, cerebral vascular accident, tracheostomy, congestive heart failure, anxiety and depression.</p> <p>A fall risk evaluation dated 1/22/19 for Resident #38 identified a score of "1" which indicated resident was not at risk for falls. The evaluation had sections that were not completed.</p> <p>A resident care guide dated 2/21/19 stated the resident required the aid of 2 persons and mechanical lift for transfers.</p> <p>Review of the physical therapy plan of care dated 2/22/19 for Resident #38 revealed she was referred to therapy to assess use of her new motorized wheelchair. Physical therapy was needed to improve her balance and fall recovery skills to decrease her risk for falls. Assessment of current transfer status was not completed.</p> <p>A quarterly minimum data set (MDS) dated 3/7/19 for Resident #38 revealed she required extensive two-person assistance with transfers, balance was not steady and required staff assistance to stabilize with transfers from bed to chair. She had impaired range of motion of upper / lower extremity on one side, had not experienced any falls, had modified independent cognition and no refusal of care behaviors during the look-back period.</p>	F 689	<p>On 4/2/2019 an in service with Certified Nursing Assistant was initiated and completed by 4/9/2019. All new hired staff in serviced on the review of the care guide before care is delivered to the residents.</p> <p>On 5/28/2019 an in service was initiated by the Director of Nursing for all Certified Nursing Assistance to use the care guides for transferring a residents. Completion will be 6/1/2019. All new hires will be in serviced during orientation.</p> <p>On 5/28/2019 an in service was initiated by the Director of Nursing for Certified Nursing Assistance not to deviate from the care guide directions specifically on resident transfers.</p> <p>A tool was comprised by the Director of Nursing on 5/28/2019 titled Appropriate Transfer of Residents Audit Tool.</p> <p>On 5/28/2019 the Director of Nursing in serviced the administrative nurse consisting of the Assistant Director of Nursing and the Staff Facilitator on usage.</p> <p>Certified Nursing Assistants will demonstrate care guide usage to the nursing administrative team. Immediate reeducation will be delivered by the administrative nurse if deficiency noted, 100 % completion by 6/1/2019.</p>		

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F 689	<p>Continued From page 7</p> <p>An incident note dated 4/2/19 at 12:08 pm indicated Resident #38 was transferred from the bed to the chair. The resident slid on her feet. While the resident was sliding, NA #1 lowered her down to the floor safely. Prior to the transfer, the resident refused to put her shoes on. The resident was observed to be lying flat on the floor. She was assessed and noted swelling of her right outer ankle and right knee. The resident complained of pain with range of motion. The resident was placed back to bed with assistance from other staff members. No other bruises or active bleeding noted. The resident 's physician was notified, and an order received to x-ray her right knee and ankle. Notified the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON) and message was left for resident 's responsible party.</p> <p>An interview on 5/9/19 at 9:30 am with NA #1 revealed she was the NA for Resident #38 on 4/2/19. She stated mid-to-late morning she was getting the resident from the bed to the chair after she had gotten her dressed. She stated the resident would not allow her to put her shoes on and the resident had on regular socks. NA #1 explained the resident was sitting on the side of her bed which was in the regular position and when she transferred her, the resident 's right leg slipped backwards, and she aided the resident to the floor. She added the resident was on her back with her right leg bent backwards underneath her. NA #1 stated she called for the nurse to assess the resident. She explained at the time of the fall the resident was a 1 person transfer from bed to chair and the resident could pivot on one of her legs. She stated she was alone when she did the transfer. NA #1 stated she knew what type of</p>	F 689	<p>6 Certified Assistant on alternating shifts will be observed by the administrative nurses with return demonstration weekly X 12 weeks. Immediate reeducation will be delivered by the administrative nurse if needed.</p> <p>The monthly QAPI committee consisting of Administrator, Director of Nursing, Staff Facilitator, Assistant Director of Nursing, Dietary manager, Activities directors, and Social workers. Will review the results of the audit tools monthly for 3 months and as needed for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QAPI committee and to the quarterly QAPI committee consisting of Medical Directors, Pharmacy Consultant, Administrator, Director of Nursing, Staff Facilitator, and Assistant Director of Nursing, Dietary Manager, Activities Directors, and Social Workers for further recommendations and oversight.</p> <p>The Director of Nursing is responsible for the implementation of an acceptable plan of correction.</p>		

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F 689	<p>Continued From page 8</p> <p>assistance a resident needed by looking at their care guide. She added the therapy department determined how a resident should be transferred.</p> <p>An interview on 5/8/19 at 3:52 pm with Nurse #2 revealed she was the nurse for Resident #38 on 4/2/19 and assessed her after her fall. She stated NA #1 called her into the resident ' s room and when she arrived the resident was lying on the floor next to her bed on her back. She stated NA #1 told her the resident started to slip while she was transferring her from the bed to the chair and NA #1 aided the resident to the floor. Nurse #2 added NA #1 told her that the resident wouldn ' t put her shoes on before the transfer, was wearing regular socks and that was why she slipped on the floor. Nurse #2 explained the resident was a 2 person assist for transfers and would often refuse to let the staff use the lift with transfers . Nurse #2 stated she was not sure if NA #1 had transferred the resident by herself or if she had another staff member with her. She explained the resident had some swelling of her right leg and when she notified the resident ' s physician he ordered x-rays. Nurse #2 stated the x-rays showed a fracture of her right leg and the resident was sent out to the hospital for treatment.</p> <p>Review of the radiology report dated 4/2/19 for Resident #38 revealed a 2-view x-ray of her right tibia / fibula showed an acute comminuted fracture at the distal shaft of the visualized right femur. A 2-view x-ray of the right ankle revealed no acute fracture or dislocation. The visualized bony structure appeared osteopenic.</p> <p>Review of a nursing note dated 4/2/19 at 2:50 pm for Resident #38 revealed she was alert and non-verbal, able to follow directions. The x-ray of</p>	F 689			

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F 689	<p>Continued From page 9</p> <p>her right knee and ankle revealed an acute comminuted fracture of the distal shaft of the visualized right femur. Her physician was notified and received an order to send the resident to the emergency room.</p> <p>Review of the emergency department record for Resident #38 dated 4/2/19 revealed the patient fell when she was transferred from the bed and slid on the floor at about 11:00 am. She had pain in her right knee and right hip. The right knee was mildly swollen. Noted on x-ray she had a closed fracture of the right distal femur. Orthopedic surgery was consulted, and plan was to continue with non-operative treatment as patient was high risk for surgery and wheelchair bound at baseline.</p> <p>Review of the medical record revealed Resident #38 was readmitted to the facility on 4/5/19 with diagnosis of closed fracture of the right distal femur.</p> <p>An observation of Resident #38 on 5/6/19 at 4:35 pm revealed she was lying in bed and the bed was in a low position. She was observed to have a soft cast on her right leg from her upper mid-thigh to mid-calf. Her right foot appeared swollen. The resident used hand gestures and verbalized noises but was unable to speak or carry on a conversation.</p> <p>An observation of Resident #38 on 5/7/19 at 10:15 am revealed she was lying in bed and the bed was in a low position. The resident would not allow observation of her right leg.</p> <p>An observation of Resident #38 on 5/8/19 at 4:02 pm revealed she was lying in bed. She was alert and awake. A soft cast was present on her right</p>	F 689			

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F 689	<p>Continued From page 10 leg.</p> <p>An interview on 5/9/19 at 9:43 am with the Rehab Director (RD) revealed the therapy and nursing departments worked together to determine a resident ' s transfer status. She stated Resident #38 had been seen by physical therapy 2/22/19 through 4/2/19. The RD explained the resident had a new motorized wheelchair and therapy had picked her up to assess her for safety with the new chair. She reviewed the physical therapy assessment dated 2/22/19 and stated the goal on the assessment for transfers was for the resident to be able to transfer from bed to chair with stand by assistance. She added the assessment didn ' t indicate what her transfer status was on 2/22/19. The RD stated the resident ' s condition fluctuated from day-to-day related to her health condition and her cooperation with care. She added the resident did have behaviors of refusal of care including using the lift for transfers. The RD explained after the resident fell she inserviced the therapy staff on improved communication between therapy and nursing and the therapy department also gained additional access to the resident ' s electronic care guides.</p> <p>An interview on 5/9/19 at 9:50 am with the Physical Therapist (PT) who completed the assessment of Resident #38 on 2/22/19 revealed he had assessed the resident for safety with her new electric wheelchair. He stated when working with the resident during that time he could transfer her from bed to chair by himself and she was able to stand and pivot on one leg. The PT explained the resident ' s right side was her weak side from a previous stroke and the one person stand to pivot transfer should be done with her left leg. He added it was his understanding that</p>	F 689			

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F 689	<p>Continued From page 11</p> <p>NA #1 had attempted to transfer the resident with her weak right leg and the combination of that and the resident not having the correct footwear on were a concern.</p> <p>An interview on 5/9/19 at 10:48 am with the DON revealed she was familiar with the fall Resident #38 had on 4/2/19 and she expected the NAs to follow the care guides when determining how to transfer a resident. The DON provided a copy of the care guide dated 4/2/19 and it stated Resident #38 was a 2 person transfer with a lift. The DON added she believed NA #1 had seen therapy transfer the resident with a one person assist and that may be why NA #1 attempted the transfer by herself. She stated after the incident the nursing staff were inserviced on use of the care guides.</p> <p>A follow-up interview with the PT on 5/9/19 at 11:05 am revealed he had not changed or notified nursing that Resident #38 ' s transfer status was now a one person assist during her treatment period of 2/22/19 through 4/2/19.</p> <p>An interview on 5/9/19 at 11:47 am with the Administrator revealed after Resident #38 ' s fall she had interviewed NA #1 and suspended her for not following the care guide when transferring the resident. She stated the nursing staff were inserviced on 4/2/19 on following the resident ' s care guides. The Administrator added the facility audited all the resident ' s care guides to ensure their transfer status was correct. She stated she had not initiated any monitoring tools to verify that staff were completing transfers according to their care guides.</p> <p>An interview on 5/9/19 at 12:24 pm with the</p>	F 689			

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

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F 689	Continued From page 12 Physician for Resident #38 revealed he was aware of the resident ' s recent fall and fracture of her right femur. He stated the resident did have predisposing factors such as her right sided weakness, her weight and osteopenia, but he did believe the fall had contributed to her fracture.  An interview on 5/9/19 at 12:45 pm with the DON revealed the facility had determined the reason Resident #38 fell was because NA #1 had not followed the care guide. She stated the facility did in-service the nursing staff on using the care guides and assure that the iPad where the care guides were located could be accessed by the nursing staff. The DON added the facility was to initiate some return demonstrations by the NAs on access to the care guides. She was unable to provide any documentation that these return demonstrations were completed.  An interview on 5/9/19 at 1:07 pm with the Administrator revealed she did not have a full quality assurance plan that included documented evidence the facility had monitored that the nursing staff were transferring residents according to their care guides and plan of care.	F 689			
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)  §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 755		5/31/19	

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F 755	<p>Continued From page 13</p> <p>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-</p> <p>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and</p> <p>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, staff interview, physician interview and pharmacy interview, the facility failed to acquire pain medication from the pharmacy to ensure the administration of 4 doses of scheduled pain medication per physician order for 1 of 1 resident (Resident #51).</p> <p>Findings included:</p> <p>Resident #51 was admitted to the facility on 12-14-18 with multiple diagnoses that included chronic obstructive pulmonary disease, respiratory failure, cellulitis, chronic pain and major depression.</p>	F 755	<p>F-755</p> <p>Resident # 51 had her opioid ordered on 5/6/2019 by the Assistant Director of Nursing as stated in the 2567.</p> <p>On 5/9/2019 an audit was initiated by the Assistant Director of Nursing to ensure all residents receiving opioids were medicated as ordered by their physician and medications were available.</p>		

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F 755	<p>Continued From page 14</p> <p>Review of the physician orders dated 3-21-19 revealed Resident #51 was to receive Percocet (pain medication) 10/325mg (Milligrams) three times a day.</p> <p>The quarterly Minimum Data Set (MDS) dated 3-22-19 revealed Resident #51 was cognitively intact. Resident #51 was coded for pain.</p> <p>During an interview with Resident #51 on 5-6-19 at 5:14pm, the resident stated she had not received her regular dose of pain medication since 5-2-19 because the medication was not available. She also stated she had been having pain in her knees.</p> <p>A review of Resident #51's May 2019 Medication Administration Record (MAR) revealed on 5-3-19 the residents Percocet 10/325mg pain medication was no longer available, but the resident was provided a lower dose of Percocet for 6 doses until that medication was no longer available. The May MAR revealed Resident #51 was not provided any pain medication at 9:00pm on 5-4-19, 9:00pm on 5-5-19, 9:00am and 2:00pm on 5-6-19.</p> <p>During an interview with the Assistant Director of Nursing (ADON) on 5-8-19 at 12:00pm, she stated she was not made aware of Resident #51 being out of her pain medication until 5-6-19 at which time she stated she called the pharmacy and had it re-ordered. The ADON also stated the nursing staff was supposed to re-order medication when they saw the medication was running low and did not know why that was not done. She stated when the pharmacy was aware of a controlled substance needing ordered, the</p>	F 755	<p>An in-service was initiated 5/28/2019 by the Assistant Director of Nursing and Staff Facilitator on the process of reordering opioids from the pharmacy for licensed nurses. Completion of the in service was 6/3/2019.</p> <p>An additional in service was conducted by the consulting pharmacist on the process of reordering opioids from the pharmacy on 5/28/2019 for licensed nursing staff.</p> <p>Administrative nurses will utilize the Pain Audit Tool .</p> <p>Administrative nurses will audit all residents receiving opioids twice weekly X 12 weeks to ensure all residents are receiving opioids as ordered by the physician and medications are available.</p> <p>The monthly QAPI committee consisting of Administrator, Director of Nursing, Staff Facilitator, Assistant Director of Nursing, Dietary manager, Activities directors, and Social workers. Will review the results of the audit tools monthly for 3 months and as needed for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QAPI committee and to the quarterly QAPI committee consisting of</p>		

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F 755	<p>Continued From page 15</p> <p>pharmacy would fax the prescription to the doctor's office, the doctor would sign it and send it back to the pharmacy.</p> <p>An interview with the dispensing pharmacist occurred on 5-8-19 at 12:40pm. The pharmacist stated the first notification they received of Resident #51 needing more pain medication was 5-5-19 at 2:41am to the on-call pharmacy and then received another call on 5-6-19 regarding the need for the pain medication. She stated the medication was filled and sent to the facility on 5-6-19. The pharmacist stated the procedure for refilling medications was the facility staff should peel the sticker off the medication card, place it on the pharmacy sheet and fax it to the pharmacy allowing 3 days for the pharmacy to fill the medication but the pharmacist stated the steps are not followed.</p> <p>Nurse #1 was interviewed on 5-8-19 at 12:52pm. Nurse #1 stated when a resident was running low on their medication she would peel the sticker off the card and place it on a pharmacy sheet then fax it to the pharmacy. Nurse #1 stated she did not do this for Resident #51 "I forgot."</p> <p>During an interview with the facility physician on 5-8-19 at 1:00pm, the physician stated there were no records kept once a prescription was signed and sent back to the pharmacy. The physician explained he would receive a prescription from the pharmacy he would sign it and fax it back to the pharmacy then the prescription was shredded. He stated he could not say for certain when the prescription for Resident #51 was signed and sent back to the pharmacy. The physician also stated he was not aware Resident #51 missed several doses of her pain medication.</p>	F 755	<p>Medical Directors, Pharmacy Consultant, Administrator, Director of Nursing, Staff Facilitator, Assistant Director of Nursing, Dietary Manager, Activities Directors, and Social Workers for further recommendations</p>		

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F 755	Continued From page 16  The Administrator was interviewed on 5-9-19 at 1:23pm. The Administrator stated there was a system in place to re-order medication, but that "things" had been difficult because there had been "just me and the ADON trying to run this place for over a year." The Administrator stated she expected residents to receive medications as ordered by the physician.	F 755			
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)  §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  §483.45(h) Storage of Drugs and Biologicals  §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced	F 761		5/31/19	

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F 761	<p>Continued From page 17</p> <p>by:</p> <p>Based on observation and staff interviews the facility failed to properly dispose of 1 - 8 ounce bottle of Senna (medication to treat constipation) syrup that had expired April of 2019, 1 - 1.5 ounce tube of MediHoney (medication to treat wounds) that had expired in August of 2018 and 4 - 60 tablet bottles of Calcium 500 milligrams that had expired in April of 2019 in 2 of 4 medication rooms (medication room for the East hall and the medication room for the south hall) reviewed for medication storage.</p> <p>Findings included:</p> <p>1. During a review of the medication room on the East hall on 5-9-19 at 11:55am with the East hall nurse, the medication room was noted to have (1) 8-ounce bottle of Senna syrup that had expired April of 2019 and (1) 1.5-ounce tube of MediHoney that had expired in August of 2018. The East hall nurse was noted to remove the items and discard of them.</p> <p>The East hall nurse was interviewed on 5-9-19 at 12:00 noon. The nurse stated she was not sure how often the medication rooms were checked for expired medications or who was responsible for checking for expired medications.</p> <p>During an interview with the Director of Nursing (DON) on 5-9-19 at 12:05pm, the DON stated the hall nurses were responsible for checking the medication rooms weekly for expired medication. She also stated the nurses received that information during their training upon hire.</p> <p>2. The South hall medication room was observed for expired medication on 5-9-19 at 12:15pm with</p>	F 761	<p>F- 761</p> <p>On 5/9/ 2019 (1) 8 ounce bottle of Senna syrup dated April 2019 was discarded per policy as well as (1) 1.5 ounce tube of Medi-honey which had an expiration date of August 2018 by the East hall nurse. On 5/9/2019 (4) bottles of containing 60 tablets unopened for usage of Calcium supplement 500 milligrams dated April 2019 were discarded per policy by the South hall nurse.</p> <p>On 5/9/2019 the Assistant Director of Nursing completed an audit of all medication storage rooms including refrigerators, and cabinets for all expired medications. On 5/23/2019 an in-service was initiated by the Director of Nursing and designee on disposal of expired medications per facility policy for all licensed nurses. This in-service will be completed on 6/3/2019 .This in-service will be included with orientation for all newly hired licensed nursing staff.</p> <p>On 5/13/2019 an audit tool was initiated by the Interim Director of nursing to monitor, expired, unlabeled, refrigerated medications. The Interim Director of Nursing, staff facilitator, Assistant Director of Nursing and/or Treatment Nurse will audit 100% of medication storage rooms weekly x 12 weeks to ensure no expired medications are present. This audit will be documented on the medication storage audit tool.</p> <p>The monthly QAPI committee consisting of Administrator, Director of Nursing, Staff</p>		

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F 761	Continued From page 18 the South hall nurse. The medication room was noted to have (4) 60 tablet bottles of 500 milligram Calcium supplement that had expired in April 2019 on the shelf ready for use.  The South hall nurse was interviewed on 5-9-19 at 12:25pm. The nurse stated the medication room was to be reviewed weekly by the hall nurse for any expired medication. The nurse stated she had checked the medication room the week of 5-6-19 for any expired medication but "I did not see those."  During an interview with the Administrator on 5-9-19 at 1:23pm, the Administrator stated she did not understand how there were expired medications in the medication room but that she expected the nurses to remove any expired medications from medication storage.	F 761	Facilitator, Assistant Director of Nursing, Dietary manager, Activities directors, and Social workers. Will review the results of the audit tools monthly for 3 months and as needed for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QAPI committee and to the quarterly QAPI committee consisting of Medical Directors, Pharmacy Consultant, Administrator, Director of Nursing, Staff Facilitator, and Assistant Director of Nursing, Dietary Manager, Activities Directors, and Social Workers for further recommendations and oversight.  The Assistant Director of Nursing is responsible for implementation of an acceptable plan of correction.		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5)  §483.60(d) Food and drink Each resident receives and the facility provides-  §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences;  §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by:	F 806		5/31/19	

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F 806	<p>Continued From page 19</p> <p>Based on observation, record review, resident interview and staff interviews the facility failed to honor the food preferences for 3 of 20 residents reviewed for food palatability (Resident #10, #51 and #8).</p> <p>Findings included:</p> <p>1. Resident #10 was admitted to the facility on 7-20-14 with multiple diagnoses that included encephalopathy, cerebrovascular disease and dementia.</p> <p>The quarterly Minimum Data Set (MDS) dated 2-8-19 revealed Resident #10 was severely cognitively impaired and needed supervision with one person for eating.</p> <p>Resident #10's care plan dated 3-20-19 revealed a goal the resident would maintain his weight, have an average intake of 75 percent of his meal and would be able to chew and swallow his food without any difficulty. The interventions for that goal were as followed; diet as ordered, refer to the dietitian for evaluation as needed, set up tray and encourage consumption of meals and offer substitutions for uneaten food.</p> <p>A review of Resident #10's dietary card revealed a dislike for "fried foods."</p> <p>During an observation of the dinner meal on 5-6-19 at 5:50pm, Resident #10 was noted not to be eating his food and it was noted he was served fried tator tots with his meal.</p> <p>Resident #10 was interviewed on 5-6-19 at 5:50pm. The resident stated he did not like what was served and that he did not eat fried foods.</p>	F 806	<p>F806</p> <p>On 5/9/2019 resident # 10 was interviewed by the Dietary Manager and his preferences were updated. Resident # 10 was informed that certain items on the menu are baked although traditionally fried to promote adherence to dietary preferences in specific to fried foods.</p> <p>On 5/9 2019 resident # 51 was interviewed by the Dietary Manager and her preferences were update to ensure she did not received greens on her meal tray.</p> <p>On 5/9 2019 resident # 8 was interviewed by the Dietary Manager and her preferences were updated to ensure resident did not received dislikes such as white chicken meats.</p> <p>On 5/10/2019 a 100% audit of all residents <input type="checkbox"/> food preferences were being honored. Tray cards were updated in the Point Click Care system to current resident food preferences.</p> <p>On 5/23/2019 an in service was initiated by the Director of Nursing for nursing staff on checking the tray card to ensure residents have requested meal served. 100% of the nursing staff in serviced obtained on 6/1/2019. All new hires nursing staff will be in serviced during the</p>		

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F 806	<p>Continued From page 20</p> <p>The resident also stated he was served fried foods "maybe one meal a day."</p> <p>The nursing assistant (NA) #1 was interviewed on 5-6-19 at 6:00pm and she stated she did not check a resident's dietary card on the tray "I assume when it comes from the kitchen it is correct." NA #1 did state she would offer substitutions if she noticed a resident was not eating.</p> <p>An observation of Resident #10's lunch meal occurred on 5-7-19 at 1:20pm. The resident was noted to have fried hush puppies on his plate and was noted not to be eating them. Resident #10 was interviewed on 5-7-19 at 1:20pm and stated he did not like fried foods, so he was not able to eat the hush puppies.</p> <p>NA #2 was interviewed on 5-7-19 at 1:22pm. The NA stated she had not checked Resident #10's meal card "I didn't know we had to check them. I thought the kitchen did that." NA #2 did state she would offer substitutions if she noticed a resident was not eating their meal.</p> <p>The dietary manager was interviewed on 5-8-19 at 12:30pm. The manager stated she was unaware residents were not being provided the food per their preferences and that she expected the residents' meal cards to be followed.</p> <p>The Administrator was interviewed on 5-9-19 at 1:23pm. The Administrator stated she had not heard any complaints of the residents not receiving the proper foods on their meal tray and that she expected the residents to receive their food preferences per the residents' choice.</p>	F 806	<p>orientation period.</p> <p>On 5/13/2019 the dietary manager in serviced the assistance dietary manager on the usage of the Tray Line Audit Tool to ensure that all resident food preferences are being honored as the meal tray leaves the kitchen.</p> <p>On 5/14/2019 an in serviced was initiated by the dietary manager to department heads consisting of Director of Nursing, Minimum Data Set Coordinator, Admission Coordinator, Social Workers, Medical Records Supervisor and Housekeeping Supervisor, Activities Directors for use to complete audit on resident food preferences.</p> <p>The dietary manager, and / or assistant dietary manager will observe 10 residents for 5 meals weekly x 12 weeks to ensure meals are served per resident preference. Documentation of the observation will be documented on the Dietary: Tray Line Audit Tool. Audits will occur at different meal times to ensure meals delivered to resident comprise of the preferences. The department heads will monitor 10 resident's daily X 5 days for 12 weeks to ensure that food preferences are being honored. Documentation of the monitoring will be on the Menu Audit Tool.</p> <p>The monthly QAPI committee consisting of Administrator, Director of Nursing, Staff Facilitator, Assistant Director of Nursing, Dietary manager, Activities directors, and Social workers. Will review the results of the audit tools monthly for 3 months and as needed for identification of trends,</p>		

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F 806	<p>Continued From page 21</p> <p>2. Resident #51 was admitted to the facility on 12-14-18 with multiple diagnoses that included chronic obstructive pulmonary disease, respiratory failure and cellulitis.</p> <p>The quarterly Minimum Data Set (MDS) dated 3-22-19 revealed Resident #51 was cognitively intact and needed supervision with tray set up help for eating.</p> <p>A review of Resident #51's care plan dated 4-16-19 revealed a goal the resident would adhere to her diet and the interventions for the goal were; diet as ordered, obtain residents likes and dislikes and monitor compliance with diet. Resident #51's meal card was reviewed and revealed a dislike for greens.</p> <p>The dinner meal was observed for Resident #51 on 5-6-19 at 6:05pm. The resident's tray was noted to have a bowl of greens.</p> <p>Resident #51 was interviewed on 5-6-19 at 6:05pm. The resident stated she "often" received food on her tray that was listed as a dislike. She also stated she had met with dietary about her likes and dislikes "but I still get things I don't like to eat."</p> <p>The dietary manager was interviewed on 5-8-19 at 12:30pm. The manager stated she was unaware residents were not being provided the food per their preferences and that she expected the residents' meal cards to be followed.</p> <p>The Administrator was interviewed on 5-9-19 at 1:23pm. The Administrator stated she had not heard any complaints of the residents not receiving the proper foods on their meal tray and</p>	F 806	<p>actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee and to the quarterly QAPI committee consisting of Medical Directors, Pharmacy Consultant, Administrator, Director of Nursing, Staff Facilitator, and Assistant Director of Nursing, Dietary Manager, Activities Directors, and Social Workers for further recommendations and oversight.</p> <p>The dietary manager is responsible for implementing an acceptable plan of correction.</p>		

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F 806	<p>Continued From page 22</p> <p>that she expected the residents to receive their food preferences per the residents' choice.</p> <p>3. Resident #8 was admitted to the facility on 4-6-17 with multiple diagnoses that included end stage renal disease, hemiplegia and hemiparesis affecting the left side and diabetes.</p> <p>The quarterly Minimum Data Set (MDS) dated 2-5-19 revealed Resident #8 was cognitively intact and was independent with set up assistance for eating.</p> <p>Resident #8's care plan dated 3-28-19 revealed a goal the resident would maintain her weight, consume 75 percent of her meals and be able to chew and swallow her food without difficulty. The interventions for that goal were as followed; diet as ordered, offer substitutions for uneaten food and refer to the dietician for evaluation.</p> <p>A review of Resident #8's meal card revealed a dislike for chicken breast.</p> <p>An observation was made of Resident #8's lunch meal on 5-7-19 at 1:20pm. The tray was noted to have a chicken breast as the entree. It was noted the resident was not eating.</p> <p>Resident #8 was interviewed on 5-7-19 at 1:20pm. The resident stated she preferred dark meat chicken, but the kitchen sent her a breast. The resident also stated she was told there was not any dark meat chicken left when she asked for a piece of chicken that was not a breast.</p> <p>During an interview with the dietary manager on 5-7-19 at 2:35pm, she stated when a resident was admitted to the facility she would meet with</p>	F 806			

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F 806	Continued From page 23 the resident and receive their likes and dislikes and any preferences the resident may have. The dietary manager also stated there were 2 people on the tray line checking the resident's trays against the tray card before the tray was placed on the meal cart to go to the unit.  The dietary manager was interviewed on 5-8-19 at 12:30pm. The manager stated she was unaware residents were not being provided the food per their preferences and that she expected the residents' meal cards to be followed.  The Administrator was interviewed on 5-9-19 at 1:23pm. The Administrator stated she had not heard any complaints of the residents not receiving the proper foods on their meal tray and that she expected the residents to receive their food preferences per the residents' choice.	F 806			
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii)  §483.75(g) Quality assessment and assurance.  §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observation, resident and 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 April 2018 annual recertification and complaint survey to correct deficient practice in the area of Accuracy of	F 867	F 867  On 5/9/2019 the Medical Directors notified of Department of Health Services Regulatory exit with recommendation of repeat tags for Minimum Data Set assessment accuracy and expired medications in the medication storage	5/31/19	

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F 867	<p>Continued From page 24</p> <p>Assessment at Tag F 641, and Medication Storage at Tag F 761. These tags were recited on the current recertification survey dated April 9, 2019. The continued failure of the facility during two surveys showed a pattern of the facility's inability to sustain an effective Quality Assurance Program.</p> <p>Findings included:</p> <p>This is cross referenced to</p> <p>1. F 641 Based on observations record review, resident and staff interviews the facility failed to ensure the accuracy of the Minimum Data Set (MDS) assessments in the areas of activities of daily living, medications, behaviors and pressure ulcers for 5 of 20 sampled residents whose MDS assessments were reviewed. (Resident #54, Resident #81, Resident #60, Resident #95 and Resident #86).</p> <p>During the recertification and complaint survey dated April 7, 2018 the facility was cited F641. The facility failed to accurately code the MDS (Minimum Data Set) to reflect the correct discharge status for 1 of 2 residents (Resident #123) reviewed for community discharge and the facility failed to accurately code the MDS to reflect insulin administration for 1 out of 5 residents (Resident #104) reviewed for unnecessary medications.</p> <p>2.F 761 Based on observation and staff interviews the facility failed to properly dispose of 1 - 8 ounce bottle of Senna (medication to treat constipation) syrup that had expired April of 2019, 1 - 1.5 ounce tube of MediHoney (medication to treat wounds) that had expired in August of 2018</p>	F 867	<p>room by the Administrator. Increase monitoring suggested for compliance.</p> <p>On 5/15/2019 the facility QAPI Committee held a meeting to review the purpose and function of the QAA committee and review on-going compliance issues. The Administrator, DON, MDS nurse, MDS Coordinator, Maintenance Director, Supply Clerk, Dietary Manager, Assistant Dietary Manager Activity Directors, Medical Record Supervisor and Housekeeping Supervisor will attend QAPI Committee Meetings on an ongoing basis and will assign additional team members as appropriate.</p> <p>On 5/15/2019 the administrator in-serviced the department heads related to the appropriate functioning of the QAPI Committee and the purpose of the committee is to include identify issues and correct repeated deficiencies related to medication storage and inaccurate residents assessments.</p> <p>On 5/21/2019 the Administrator was in serviced on the Quality Assurance and Improvement Plan policy by a Principle Long Term Facility Consultant. Resources for further education, and ongoing support provided.</p> <p>The Facility QAPI Committee will meet at</p>		

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F 867	<p>Continued From page 25</p> <p>and 4 - 60 tablet bottles of Calcium 500 milligrams that had expired in April of 2019 in 2 of 4 medication rooms (medication room for the East hall and the medication room for the south hall) reviewed for medication storage.</p> <p>During the recertification and complaint survey dated April 7, 2018 the facility was cited F761. the facility failed to dispose of expired medications and unlabeled, opened medications in 1 out of 4 medication carts (South hall cart #2) and in 2 out of 2 medication storage rooms (East and South halls) and the facility failed to refrigerate medications in 1 out of 2 medication storage rooms (East Hall) that are used to supply medications for the residents of the facility.</p> <p>During an interview with the Administrator on 5/9/2019 at 1:57pm she indicated that her expectation for repeat tags that the QA program discuss improvements and develop audit tool to monitor each department to prevent repeat tags.</p>	F 867	<p>a minimum of monthly and QAPI committee meeting a minimum of quarterly to identify issues related to the accuracy of Minimum Data Set assessments and disposal of expired medications in the medication storage rooms.</p> <p>Cardinal IDT will be held 5X daily for 4 weeks then weekly X 4 weeks, Then bi-monthly X2 month utilizing the monitoring tools.</p> <p>The QAPI committee will continue to meet at a minimum of Quarterly.</p> <p>The QAPI Committee, includes the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Staff Facilitator, Social Workers, and Activity Directors will review quarterly compiled QAPI report information, review trends, and review corrective actions taken and the dates of completion. The QAPI Committee will validate the facility's progress in correction of deficient practices or identify concerns. The administrator will be responsible for ensuring committee concerns are addressed through further training or other interventions.</p> <p>The administrator is responsible for the implementation of an acceptable plan of correction</p>		