STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN HOME HEALTH AND REHAB	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

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E 000	Initial Comments An unannounced recertification survey was conducted on 05/13/19 through 05/16/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID TFNQ11.	E 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		6/13/19

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

Electronically Signed | 06/07/2019

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F 584	Continued From page 1 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain the ceiling in good repair for 2 of 22 resident rooms on 1 of 2 halls (room #316 and #318) and failed to maintain a baseboard in good repair for 1 of 22 resident rooms on 1 of 2 halls reviewed for environment (room #318). Findings included: 1. An observation of the bathroom ceiling of room 316 on 05/13/19 at 11:04 PM revealed a portion of the popcorn ceiling was dangling and exposed the drywall of the ceiling. An observation of the bathroom ceiling also revealed a large discolored area with a black substance in the discolored area. An observation of the bathroom ceiling of room 316 on 05/14/19 at 3:01 PM revealed a portion of the popcorn ceiling was dangling and exposed the drywall of the ceiling. An observation of the bathroom ceiling also revealed a large discolored area with a black substance in the discolored area. An interview with the Maintenance Director on	F 584	A. Loosened baseboards in room 316 were securely attached on 6/12/2019 using an industrial glue designed for baseboard attachment.The bathroom ceiling of room 316 was repaired by removing the dark area and replacing with new drywall. It was then painted and the popcorn effect reapplied. All ceiling repairs to room 316 were completed on 5/17/2019. 2. The bathroom ceiling of room 318 was repaired by removing the damaged, darkened portion of the ceiling, replacing with new drywall, painting and restoring the popcorn effect on 5/17/2019. 3. The baseboard of room 318 at the bathroom door was properly secured to the wall with industrial glue on 6/12/2019. B. The Maintenance Director completed an inspection of all resident rooms and bathrooms to identify damaged areas of the ceilings, baseboard and walls; list any damage to those or other areas found and schedule those repairs. This inspection	

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F 584	Continued From page 2 05/14/19 at 3:01 PM revealed he was not aware of a portion of the popcorn ceiling dangling in room 316. The Maintenance Director removed the dangling portion of the popcorn ceiling and touched the underlying exposed drywall with his finger causing his index finger to go through the drywall leaving a hole in the exposed drywall. He stated the discolored area and black substance in the ceiling was a result of a water leak in the past and he was not aware of the popcorn ceiling dangling or the water leak stain on the bathroom ceiling of room 316. The Maintenance Director noted he had not done room audits since August 2018 because he had been really busy and was also helping do transports for the facility. The Maintenance Director stated he was informed by staff of repairs that needed to be made by written work orders or verbally and he stated he had not received any work orders or verbal requests to repair ceilings in any resident rooms. An interview with the Administrator on 05/14/19 at 3:29 PM revealed the facility had some water leaks in the past that caused the ceiling discoloration. She stated she expected the Maintenance Director to round monthly to check for needed repairs but knew he had been very busy lately because he had also been helping do facility transports. The Administrator stated the Maintenance Director was no longer doing facility transports as of May 2, 2019 and stated the facility had a Guardian Angel program that assigned facility staff to specific residents. The assigned Guardian Angel was responsible for rounding on the resident and also assessing resident rooms. Between rounding by the Maintenance Director and rounding by Guardian Angels the ceiling issues should have been identified and reported so they could have been	F 584	was completed 6/10/19. Repairs were completed to identified damaged areas on 6/12/19. C(1)To assure damage and wear and tear do not go unnoticed or unrepaired, the Maintenance Director will complete weekly rounds of all resident rooms and bathrooms, noting any areas of concern related to damage as well as well and tear beginning on 6/10/19. Dark areas on ceilings, dangling popcorn ceiling, unsecured baseboards and other signs of damage or wear will be completed within 7 days of identification on an ongoing basis. C(2)The CEO completed an all staff in-service on 6/12/19 during which staff was instructed on how to identify and report any signs of damage to patient rooms and bathrooms using a written work order. The importance of timely reporting was stressed. To assure the ongoing and consistent reporting, new employee orientation now includes this important aspect of caring for residents' physical environment. C(3)To assure areas of concern are resolved, CEO will be provided copies of all work requests and/or reports of concerns in order to validate that the work has been properly completed by observing the areas addressed in the work orders approximately 7 days after the work order is written. The CEO will make random checks on 5 resident rooms each week for 90 days to assure the maintenance director is identifying all areas of concern. These random checks and validation began on 6/13/19.	

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F 584	Continued From page 3 fixed. 2. An observation of the bathroom ceiling of room 318 on 05/13/19 at 2:46 PM revealed a circular portion of the popcorn ceiling was missing and exposed the drywall of the ceiling. An observation of the baseboard in room 318 A at the bathroom door on 05/13/19 at 2:47 PM revealed a part of the baseboard had peeled away from the wall. An observation of the bathroom ceiling of room 318 on 05/14/19 at 3:05 PM revealed a circular portion of the popcorn ceiling was missing and exposed the drywall of the ceiling. An observation of the baseboard in room 318 A at the bathroom door on 05/14/19 at 3:05 PM revealed a part of the baseboard had peeled away from the wall. An interview with the Maintenance Director on 05/14/19 at 3:05 PM revealed he was not aware of the missing area of the popcorn ceiling in the bathroom of 318 or that the baseboard had peeled away from the wall in room 318 A but had not done room audits since August of 2018. He stated he had not gotten any work orders or verbal requests to repair the baseboard in room 318 A. The Maintenance Director noted he had been really busy and had just not gotten around to checking on repairs in resident rooms. He further stated he had also been helping do facility transports. An interview with the Administrator on 05/14/19 at 3:29 PM revealed she would not expect part of the popcorn ceiling to be missing or the	F 584	D. The Maintenance Director will present results of his weekly rounds at the monthly QAPI meeting along with details of repairs completed for 90 days. If the QAPI team agrees that progress is sustained, checks may go to bi-weekly for 60 days then monthly on an ongoing basis. This plan commenced on The CEO will also present findings that validate work has been completed satisfactorily to the QAPI team monthly for review and determination as to the success of this corrective action. The QAPI Committee will also consider patterns and trends that suggest the need for process change or major repairs. These recommendations will be passed from the QAPI committee through the CEO to the Regional Director of Operations. Sustaining compliance with this corrective action is the responsibility of the CEO and will be fully implemented by 6/13/2019.	

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F 584	Continued From page 4 baseboard to be partially peeled away from the wall. She stated she expected the Maintenance Director to round monthly to check for needed repairs but knew he had been very busy lately because he had also been helping do facility transports. The Administrator stated the Maintenance Director was no longer doing facility transports as of May 2, 2019, and the facility had a Guardian Angel program that assigned facility staff to specific residents. The assigned Guardian Angel was responsible for rounding on the resident and also assessing resident rooms. Between rounding by the Maintenance Director and rounding by Guardian Angels the ceiling issues should have been identified and reported so they could have been fixed.	F 584		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) in the areas of medications (Resident #44) and diagnoses (Resident #24) for 2 of 20 residents reviewed for MDS accuracy. Findings included: 1. Resident #44 was admitted to the facility on 08/01/18 with multiple diagnoses that included diabetes. Review of Resident #44's medical record revealed the following physician orders:	F 641	A. The quarterly MDS for resident#44 dated 3/29/19 was modified on 5/15/19 to accurately reflect insulin injections he received. The quarterly MDS for resident #2 dated 3/3/19 was modified on 5/15/19 to accurately reflect the addition of a diagnosis of Diabetes Mellitus. B. A list of all residents having a diagnosis of diabetes was compiled from pharmacy records on 5/29/19. For each resident included on the report, the most recent MDS was audited for accurately recording a diagnosis of Diabetes Mellitus	6/13/19

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F 641	Continued From page 5 *09/12/18 read, "Lantus (insulin medication) 100 unit/milliliter (ml) vial - inject 50 units subcutaneously (SQ) at bedtime." *01/31/19 read, "Novolog 100 unit/ml vial - inject 12 units SQ before each meal. Hold for glucose readings less than 150." Review of the March 2019 medication administration record for Resident #44 revealed insulin injections were administered per physician orders. Review of the quarterly MDS dated 03/29/19 indicated under Section N Medications, Resident #44 was not coded as receiving insulin injections during the 7-day assessment period. During an interview on 05/15/19 at 1:50 PM the MDS Coordinator confirmed Resident #44 received insulin for his diagnosis of diabetes and stated she missed coding he received daily insulin injections on the MDS dated 03/29/19. She added a modification would be submitted to accurately reflect he received insulin injections. During an interview on 05/15/19 at 2:50 PM, the Director of Nursing stated she would expect MDS assessments to be accurately coded. 2. Resident #24 was readmitted to the facility on 07/14/15. A review of a care plan indicated a new problem onset on 07/05/17 for diabetes mellitus for Resident #24. A physician's order for Resident #24 dated 10/22/18 indicated staff were to begin Humalog insulin with previous sliding scale values.	F 641	in section I of the MDS as well as documentation of insulin injections in section N of the MDS. This audit was commpleted by the DON on 5/29/19. The Regional MDS Consultant educated the MDS Coordinator about the importance of accurately recording diagnosis and procedures including injections on the MDS on 5/15/19. The DON reviewed the clinical process of daily order review to recognize changes in diagnosis and new orders for injections with the MDS Coordinator on 5/15/19. C.1) On a weekly basis MDS documents that are completed but not yet submitted are reviewed by the DON and MDS nurse to assure new orders and order changes are accurately reflected in the MDS coding of Sections I and N beginning on 6/13/19. 2)Beginning with June reports, on a monthly basis, pharmacy reports for diagnosis and new orders will be reconciled against completed MDS to validate the accuracy of data entered for 3 months. 3) Each new admission MDS will be reconciled against physician's orders to assure accurate coding of Diagnoses and injections by the DON for 3 months beginning on 6/13/19. Any discrepancies identified in these audits will be resolved immediately and education provided to assure the incorrect documentation does not continue. The data from these audits will be recorded on an audit tool for review at QAPI. D. The DON will bring the audit tools to monthly QAPI meetings beginning with	

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F 641	Continued From page 6 A review of the monthly physician's orders from 02/01/19 to 03/31/19 for Resident #24 indicated a physician's order for Humalog insulin sliding scale before meals. A review of the Medication Administration Record (MAR) from 2/25/19 to 3/03/19 indicated Resident #24 received Humalog sliding scale insulin injections 6 times. A review of Resident #24's quarterly Minimum Data Set (MDS) assessment dated 03/03/19 indicated Resident #24 had not been coded under Section I Active Diagnosis as having a diagnosis of diabetes mellitus. On 05/15/19 at 10:28 AM an interview was conducted with the MDS Coordinator who stated she was responsible for coding Section I Active Diagnosis on Resident #24's quarterly MDS assessment dated 03/03/19. The MDS Coordinator stated she missed coding that Resident #24 had a diagnosis of diabetes mellitus. The MDS Coordinator stated she was aware that Resident #24 had a diagnosis of diabetes mellitus because he received insulin. The MDS Coordinator stated she would have to submit a modification to the quarterly MDS assessment dated 03/03/19 to accurately reflect Resident #24 had a diagnoses of diabetes mellitus. On 05/15/19 at 10:40 AM an interview was conducted with the Director of Nursing (DON) who stated her expectation was that the quarterly MDS assessment dated 03/03/19 would have been accurately coded to reflect Resident #24 had a diagnosis of diabetes mellitus. The DON	F 641	the June meeting for three months to review the findings. The QAPI Committee will determine whether to continue the audits based on findings. . The DON is responsible for sustaining compliance with this corrective action which will be fully implemented by 6/13/19 Completion date is 6/13/2019	

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F 641	Continued From page 7 stated her expectation was that the MDS Coordinator would submit a modification to the quarterly MDS assessment dated 03/03/19 to reflect Resident #24 had a diagnoses of diabetes mellitus. On 05/15/19 at 12:05 PM an interview was conducted with the Administrator who stated her expectation was that the quarterly MDS assessment dated 03/03/19 would have been accurately coded to reflect Resident #24 had a diagnoses of diabetes mellitus. The Administrator stated she was aware that Resident #24 had diabetes mellitus. The Administrator stated her expectation was that the MDS Coordinator would submit a modification to the quarterly MDS assessment dated 03/03/19 to reflect Resident #24 had a diagnoses of diabetes mellitus.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656		6/13/19

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F 656	Continued From page 8 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a comprehensive care plan for anticoagulation medication use for 1 of 5 residents reviewed for unnecessary medications (Resident #71). Findings included: Resident #71 was admitted to the facility 11/07/18 with diagnoses including hypertension (high blood pressure) and atrial fibrillation (an irregular heart rate). Review of Resident #71 Physician's orders	F 656	A. A Care Plan focus for use and monitoring of anticoagulants was added to resident #71s Care Plan on 5/16/19. B. (1) A list of all residents on precribed anticoagulants was compiled on 5/28/19. (2) Each resident who is receiving anticoagulant therapy now has a care plan which addresses the risks and benefits of that anticoagulation therapy as of 5/30/19. These updated care plans were shared with the nursing team to ensure each caregiver understands the importance of monitoring residents for potential side	

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F 656	Continued From page 9 revealed an order dated 03/07/19 for Xarelto (an anticoagulant) 20 milligrams (mg) once a day for atrial fibrillation. Review of the quarterly Minimum Data Set (MDS) dated 04/30/19 revealed Resident #71 was moderately cognitively intact and received an anticoagulant 7 out of 7 days during the assessment period. Review of Resident #71's care plan last updated 05/01/19 revealed there was no care plan for anticoagulant use. An interview with the MDS Coordinator on 05/15/19 at 5:27 PM revealed she completed Resident #71's MDS dated 04/30/19 and was responsible for initiating new care plans. The MDS Coordinator stated the anticoagulant care plan should have been initiated when the order was received for Xarelto. The MDS Coordinator stated Resident #71 should have had a care plan addressing anticoagulant use and it just got missed. An interview with the Director of Nursing (DON) on 05/16/19 at 9:33 AM revealed the MDS Coordinator was responsible for developing Resident #71's care plan for anticoagulant use and she would have expected Resident #71 to have a care plan for anticoagulant use.	F 656	effects of anticoagulant therapy and properly inform a supervisor for any noticed changes. All care plans for residents on anticoagulant therapy were reviewed and revised by 5/30/19. C. (1) All new orders and order changes are now reviewed at morning meeting by at least part of the nursing leadership team, which includes the DON, ADON, Unit Managers, Staff Development Coordinator and MDS Coordinator, effective 6/13/19, to assure the team is fully aware of new treatments, laboratory tests and medication changes in order to assure accurate MDS and Care Plans. This monitoring started on 6/13/19. Beginning 6/13/19 and continuing for 90 days, the DON will validate 10% of new orders against care plans and MDS data entries to assure the accuracy of information is carried through the resident's clinical record. Any discrepancies identified will be addressed and resolved immediately and education provided to assure the discrepant process does not reoccur. Data for these reviews will be collected on an audit tool for review. D. The DON will bring the completed audit tool to the monthly QAPI meeting, beginning with the June QAPI meeting, and present findings for a period of 3 months. Based on the findings collected on these audit tools, the QAPI Committee will determine the need to continue to monitoring process, increase or decrease frequency.	

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F 656	Continued From page 10	F 656	The DON is responsible for sustaining compliance with this corrective action which will be completed on 6/13/19. Completion date 6/13/19.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced	F 657		6/13/19

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F 657	Continued From page 11 by: Based on record reviews and staff interviews the facility failed to update the comprehensive care plan for 1 of 1 resident reviewed for advanced directives (Resident # 21). Findings included: Resident #21 was admitted to the facility on 10/01/05 with diagnoses which included non Alzheimer's dementia, and ischemic heart disease. The quarterly Minimum Data Set (MDS) dated 2/27/19 revealed that Resident #21 was moderately cognitively impaired. A review of the medical record revealed that Resident #21 was a Do Not Resuscitate (DNR). Resident #21 had a physician's order dated 4/19/19 for DNR and there was a DNR form completed and signed on the resident's medical record. A review of Resident #21's care plan dated 5/23/18 indicated the resident was a full code and that in the event of a cardiac arrest the facility staff would initiate resuscitation measures. An interview with the MDS Coordinator on 5/14/19 at 2:33 PM revealed she was responsible to initiate and update the resident care plans. She further revealed that she must have missed this order and did not update the care plan to remove the full code status and add the DNR status for Resident #21. She stated the facility had a clinical meeting every day to review orders written the previous day and she did not know why this was missed. The MDS Coordinator stated the care	F 657	A. The care plan of resident #21 was corrected on 5/14/19 to reflect the correct DNR status. The new care plan was written by the MDS coordinator. The Advanced directives for resident #21 now match from the physician's orders to MDS to Care Plan. B. An audit of each residents' chart to determine correctly noted code status, accurate orders in place, accurate Advanced Directive in MDS and care plan that accurately portrays the resident's wishes for advanced directives was completed 5/17/19 by the DON. Each resident's code status order was again compared to current MDS, care plan, and Golden Rod, or other Advanced Directive form to assure all documents are consistent and accurate. Corrections were made as necessary. This was completed by the MDS coordinator by 5/20/19. C. 1) All new code status orders will be reviewed daily in clinical meeting by the Clinical Leadership team with the care plan being updated as needed by the MDS coordinator, and in her absence the DON, beginning on 6/13/2019. 2) On 5/17/19 A complete review of the code status of each resident was completed comparing the physicians order, MDS and Care Plan with any discrepancies resolved. On an ongoing basis audits will be completed according to the MDS calendar taking all assessment opportunities including quarterly, annual and significant changes as well as the	

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F 657	Continued From page 12 plan should have been updated and she would correct it. An interview with the Director of Nursing (DON) on 5/14/19 at 2:42 PM revealed that Resident #21's change in code status should have been updated on the care plan. An interview with the Administrator on 5/14/19 at 2:46 PM revealed the order should have been reviewed in the daily clinical meeting and the care plan should have been changed to reflect the correct code status.	F 657	newly admitted residents on the 5 day and Comprehensive by a team that includes the social worker, DON or representative and the MDS coordinator, to assure that all documents properly represent the wishes of the resident and each document is consistent in accordance with the resident's code status. 3)Newly admitted residents, or their chosen representative(s) will be interviewed by the Social Worker before or during Baseline Care Plan meeting to ensure that questions are answered and the resident or his/her representative fully understand their choices and that their choice is correctly noted in the resident's care plan, and are consistent with proper physician's orders and the MDS accurately represents those wishes beginning 6/13/19. D. Data collected during the monthly audit will be presented at the monthly QAPI meeting and will focus on accurate and consistent documentation beginning with the June QAPI meeting and continuing f0r 90 days. The QAPI Committee will review the data and determine if the monitoring should continue based on findings. The Administrator is responsible for sustaining compliance with this corrective action which will be completed by 6/13/19. Completion date of 6/13/2019	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		6/13/19

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F 689	Continued From page 13 §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 and Nurse Practitioner, Physician and staff interviews, the facility failed to safely transfer a dependent resident using a mechanical lift with 2-person assist causing the need for an ankle x-ray when swelling later developed for 1 of 4 residents reviewed for accidents (Resident #7). The findings included: Resident #7 was admitted to the facility on 03/28/12 with multiple diagnoses that included cerebral infarction (stroke), hemiplegia (paralysis on one side of the body) right dominant side and edema. Review of Resident #7's Activities of Daily Living (ADL) and fall care plans, with onset dates of 03/31/17, addressed her need for staff assistance due to right hemiplegia, poor safety awareness, and decline in cognition and independent mobility. Interventions included 2-person assist with mechanical lift for all transfers. Review of the annual Minimum Data Set (MDS) dated 02/13/19 assessed Resident #7 with severe cognitive impairment. Further review revealed Resident #7 required extensive to total staff assistance with all activities of daily living.	F 689	A. Resident # 7 was transferred by CNA #1 using a hoyer lift without the assistance of a second person as is required by policy. It was determined on 3/26 and confirmed on 3/27 that resident #7 had sustained a fracture at some point prior to the 3/26 evaluation and believed to have occurred during the transfer with the assistance of one, CNA #1. Because of resident #7's disuse of lower extremities and diagnosed osteoporosis, the Nurse Practitioner and Attending physician agreed that minimal trauma would be required to sustain a fracture. As CNA #1 did not obtain the assistance of a second person, CNA#1 was given a verbal reprimand for failing to follow a strict policy of using two persons with every hoyer transfer. CNA #1 was individually educated about the seriousness of this infraction and the requirement to always use a second person to assist with hoyer tranfer on 3/27/19. This information about number of staff needed to assist the resident is recorded on the resident's care sheet to assure staff is fully aware of requirements. B. A review of all care plans was	

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F 689	Continued From page 14 Review of a nurses' note dated 03/26/19 read in part, "right foot swollen (non-pitting), no redness or warmth; however, moderately tender. Will forward to Physician for evaluation." Review of an incident and accident form dated 03/26/19 read in part, "on the morning of 03/26/19, Resident #7 was noted to have edema in the right ankle. No discoloration noted. Physician notified. Resident #7 taken to the hospital for evaluation." Review of Resident #7's medical record revealed the following physician orders: *03/26/19 read in part, 3-view x-ray of right ankle/foot related to pain; ultrasound of right leg to rule out Deep Vein Thrombosis (DVT; blood clot that causes swelling, pain and tenderness often in the legs). *03/27/19 read in part, schedule Computed Tomography (CT; detailed x-ray images) scan of right ankle to rule out fracture. Review of the right ankle x-ray results dated 03/26/19 read in part, "chronic changes with no obvious or grossly displaced fracture. Occult hairline fracture or obscured nondisplaced fracture is not excluded. Consider repeat study or CT if symptoms are worsening or persistent." Review of the right ankle CT scan results dated 03/27/19 indicated a "likely acute, nondisplaced bimalleolar (ankle) fracture on a background of chronic disuse (state of not being used) osteoporosis (brittle bones)." Resident #7 was unable to be interviewed due to cognition.	F 689	completed to identify other resident who have been determined to require the use of mechanical lifts on 5/20/19. Each was then audited to assure the transfer requirement was noted on "care sheets" which are provided to CNAs to inform them of care requirements including tranfers of the residents on their assignments. This audit was completed by the DON on 5/20/19. C. To be certain information about appropriate transfer method is up to date and available, new orders are reviewed at morning clinical meeting by the Nursing leadership team with changes made on the Care Sheets effective 6/13/19. On 6/12/19 all nursing staff were again in-serviced on proper and safe use of the hoyer mechanical lift for transfers of residents, especially those who are frail and fragile with an emphasis on the use of two persons with every hoyer transfer. To assure this policy is known to new employees as well, all new nursing staff orientees will be instructed on the proper way to transfer residents using the mechanical lift (hoyer). This instruction includes the requirement that 2 staff members participate with all mechanical lift (hoyer) transfers to ensure the safety of the resident. In-servicing had been initiated on 3/25/19 and is ongoing and recorded in the orientation process.(2) Charge nurses have been instructed to monitor their unit for strict adherence to this policy by the DON and the SDC. Effective 6/13/19, DON and SDC will each conduct 3 random observations of	

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F 689	Continued From page 15 During an interview on 05/15/19 at 10:41 AM, NA #3 confirmed she was assigned to provide care to Resident #7 on 03/25/19 during the hours of 7:00 AM to 3:00 PM. NA #3 stated Resident #7 required 2-person assist using a mechanical lift for all transfers. NA #3 did not recall noticing any swelling to Resident #7's ankle and added she displayed no signs or symptoms of pain when care was provided during the shift. During a telephone interview on 05/16/19 at 2:02 PM, NA #4 confirmed she was assigned to provide care to Resident #7 on 03/25/19 during the hours of 3:00 PM to 11:00 PM. NA #4 stated Resident #7 was already in bed at the start of her shift and was not transferred out of bed during her shift on 03/25/19. NA #4 explained Resident #7 required 2-person assist using a mechanical lift for all transfers. NA #4 added she noticed no swelling to Resident #7's ankle nor recalled Resident #7 displaying any signs of pain when care was provided. During a telephone interview on 05/16/19 at 2:13 PM, NA #1 confirmed she was assigned to provide care to Resident #7 during the hours of 11:00 PM to 7:00 AM on 03/24/19 to 03/25/19 and admitted she had transferred Resident #7 independently out of bed using a mechanical lift. NA #1 acknowledged she was supposed to ask for assistance when transferring Resident #7 in or out of bed and normally requested assistance but did not on the morning of 03/25/19. NA #1 explained she was able to maneuver the sling while operating the mechanical lift independently and denied bumping or hitting Resident #7's leg on the lift. She stated when Resident #7 was placed into the geri-chair, she noticed no swelling	F 689	transfers each week noting any concerns with the method or process of transfer and assuring the correct number of assistants. Data validating these observations will be collected on an audit tool. D. The audit tool that validates random observations of resident transfers as well as in-service materials collected during orientation and or daily Care Sheet changes will be presented by by the DON at the monthly QAPI meeting beginning in June of 19 and continuing for 3 months. At that time the QAPI Committee will determine the effectiveness of these corrective actions as well as the need to continue for an additional 3 months based on findings. The DON is responsible for sustaining compliance with this corrective action which is fully implemented on 6/13/19. Completion date is 6/13/2019	

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F 689	Continued From page 16	F 689		

to Resident #7's lower extremities nor did Resident #7 display any signs or symptoms of pain or discomfort during or after the transfer. NA #1 indicated on the morning of 03/26/19, she provided care to Resident #7 while she was still in bed and when she had pulled the covers off her legs, noticed her right ankle appeared swollen. NA #1 stated she immediately notified Nurse #3 who came into the room and assessed Resident #7.

During a telephone interview on 5/15/19 at 12:00 PM, Nurse #3 confirmed she was assigned to care for Resident #7 on 03/25/19 to 03/26/19 during the hours of 11:00 PM to 7:00 AM. Nurse #3 stated she was informed by NA #1 on 03/26/19 she had noticed during care that Resident #7's right ankle was swollen. Nurse #3 indicated upon assessment, Resident #7's ankle was slightly swollen but had no deformity, redness or bruising. She added resident was nonverbal and displayed no signs of pain or discomfort during the assessment. Nurse #3 indicated her assessment of Resident #7's ankle revealed "nothing that looked like an acute injury" and a note was left for the Physician to evaluate.

During an interview on 05/16/19 at 1:19 PM, the Director of Nursing (DON) confirmed she was notified of Resident #7's fracture and immediately started an investigation to determine the root cause. The DON stated during employee interviews, NA #1 admitted she had transferred Resident #7 on 03/25/19 using a mechanical lift without additional staff assistance but denied bumping her leg or ankle during the transfer. The DON stated it was difficult to determine what caused Resident #7's fracture and concluded the injury most likely occurred when she was

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F 689	Continued From page 17 transferred on the morning of 03/25/19 by NA #1 as they felt it was difficult for staff to safely operate a mechanical lift independently when transferring a resident. She confirmed it was facility policy to have 2-person staff assist when transferring a resident using a mechanical lift and added she would have expected for NA #1 to have followed facility policy when transferring Resident #7. During an interview on 05/16/19 at 1:30 PM the Nurse Practitioner (NP) stated Resident #7 had edema in the lower extremities and severe osteoporosis. She confirmed she assessed Resident #7's ankle and explained her bones were very brittle due to osteoporosis and nonuse of her lower extremities and could easily break with or without trauma. The NP added any type of movement such as turning and repositioning or getting the ankle tangled in the bed covers could cause her bones to break. During an interview on 05/15/19 at 3:02 PM the Medical Director (MD) stated Resident #7 was non-ambulatory, had osteoporosis and multiple contractures. He explained, due to her osteoporosis, there were several things that could have contributed to her sustaining an ankle fracture such as bumping her leg on the mechanical lift during a transfer or simply being repositioned while in bed. The MD added due to her debility, it was difficult to determine the true cause of the fracture.	F 689		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes,	F 693		6/13/19

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F 693	Continued From page 18 both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews the facility failed to administer a tube feeding as ordered by the Physician for 1 of 1 residents reviewed for tube feeding (Resident #63). Findings included: Resident #63 was admitted to the facility 01/18/19 with diagnoses including drug induced subacute dyskinesia. Review of the quarterly Minimum Data Set (MDS) dated 04/20/19 revealed Resident #63 was moderately cognitively intact, had a feeding tube, received 51% or more calories from tube feeding, and received 501 cubic centimeters (CCs) or	F 693	A. Resident #63 was ordered to have an enteral feeding of Jevity1.5 to start at 3 pm daily and run at 90 cc/hr until 7 am each day. On 5/14/19 the tube feeding was not started until 4:30 pm due to confusion as to which nurse was responsible for the start up. The Physician was notified and orders received to continue tube feeding until 8:30 am on the morning of 5/15/19 to ensure that the resident received the ordered amount of nutrition. The Physician also ordered that the time for the start of the tube feeding be changed to 2 pm each day to improve compliance with timing and assure each shift is fully aware of their role in providing enteral	

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F 693	Continued From page 19 more fluid intake from tube feeding. Review of the tube feeding order for Resident #63 dated 03/27/19 revealed he was to receive Jevity 1.5 (a tube feeding formula) at 90cc/hour starting at 3:00 PM and continuing until 7:00 AM. Review of Resident #63's care plan for being at risk for complications of g-tube feedings last updated 04/19/19 revealed his tube feedings and flushes were to be administered as ordered. An observation of Resident #63 on 05/14/19 at 4:15 PM revealed he was in bed watching television and no tube feeding was infusing. An interview with Resident #63 at 4:17 PM revealed his tube feeding should have been started at 3:00 PM and he liked his tube feedings to be started on time. Resident #63 stated usually his feedings were started between 3:00 PM and 3:30 PM. An interview with Nurse #1 on 05/14/19 at 4:20 PM revealed she thought Resident #63's tube feeding was not due to be started until 6:00 PM because that was what she was told in report. Nurse #1 checked the Medication Administration Record (MAR) for Resident #63 and confirmed a Physician's order stating his tube feeding was to be started at 3:00 PM. Nurse #1 stated she was a new employee and had only been working at the facility a few days and was not familiar with all the residents' orders. An interview with the Director of Nursing (DON) on 05/14/19 at 4:33 PM revealed that a tube feeding ordered by the Physician to be started at 3:00 PM should have been started by now. The	F 693	nutrition. B. Through review of physicians order sheets provided by the pharmacy it was confirmed that Resident #63 is the only resident who is receiving enteral feedings at the facility. C. Tube feedings are recorded on the Medication Administration Record(MAR) to assure nurses are aware of the orders. To avoid any confusion that may occur at change of shift, the facility determined that orders such as enteral feeding orders will not be set up for change of shift time. Staff was in-serviced on this change on 5/15/19 to assure staff was fully aware of the time change for resident #63. In-service included clarification that nurses on the 7-3 shift will start and document tube feeding start time daily on the MAR This documentation will begin 5/15/19. This documentation will be reviewed by DON or designee in clinical meeting each morning to assure the resident is receiving full feeding and that it is properly documented beginning on 6/13/19. D. DON will collect the data from daily review on an audit tool and provide it to QAPI on a monthly basis beginning with June 2019 and continuing for 3 months or until QAPI determined that the corrective action has been sustained for at least 30 days without lapse. POC completed by 6/13/2019 The DON is responsible for sustaining	

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F 693	Continued From page 20 DON stated she expected the 7:00 AM to 3:00 PM shift to have started Resident #63's tube feeding. An interview with Nurse #2 on 05/14/19 at 4:53 PM revealed she worked the 7:00 AM to 3:00 PM shift on 05/14/19 and cared for Resident #63. Nurse #2 stated Resident #63's tube feeding was ordered to be started at 3:00 PM and the 3:00 PM to 11:00 PM shift was supposed to start the tube feeding. Nurse #2 stated the 3:00 PM to 11:00 PM always started Resident #63's tube feeding. Nurse #2 stated she told Nurse #1 in report that Resident #63's tube feeding was supposed to be started at 3:00 PM. An interview with the Physician on 05/14/19 at 5:05 PM revealed he expected a tube feeding that was ordered to begin at 3:00 PM to be started around 3:00 PM. The Physician stated if the tube feeding was not started at or around 3:00 PM he would expect staff to notify him or his Nurse Practitioner (NP) for new orders.	F 693	compliance with this corrective action which is fully implemented on 6/13/19. Completion date 6/13/19.	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.	F 756		6/13/19

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F 756	Continued From page 21 (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff, consultant pharmacist (CP), and adult nurse practitioner interviews the facility failed to act upon a pharmacy recommendation and the monthly pharmacist's review did not include the lack of a specified duration for an as needed (prn) psychotropic medication for 1 of 4 residents reviewed for falls (Resident #6). Findings included: Resident #6 was admitted to the facility on	F 756	A. Resident #6 had not used PRN Trazodone in the month of April or May. The medication was discontinued on 5/16/19 due to non use. During the course of its use, the pharmacy consultant had requested clarification of duration of the medication course as well as a physician's statement validating the need for the medication. B. A pharmacy report was prepared that identifies all residents being administered	

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F 756	Continued From page 22 11/05/18 with diagnoses which included depression and anxiety. A review of the physician's order dated 12/31/18 indicated Trazodone (an antidepressant) 25 milligrams (mg) by mouth twice a day prn for aggression was ordered for Resident #6 by the adult nurse practitioner (ANP). There was no 14 day stop date written for this prn Trazodone order. A review of the Medication Administration Records (MARs) revealed per staff documentation on the MARs that Resident #6 had received 9 doses of prn Trazodone in January 2019, 2 doses in February 2019, and 4 doses in March 2019. Resident #6 was not administered any prn Trazodone in April or May 2019. A review of the Consultant Pharmacist (CP) monthly drug regimen for Resident #6 revealed on 1/27/19 the CP recommended the physician document the rationale in the chart and indicate a duration of Resident #6's prn Trazodone order. The handwritten prescriber response dated 2/12/19 by the ANP stated she would write a note to address the need to continue the prn Trazodone. A review of the ANP progress note dated 2/12/19 did not document the rationale to continue Resident #6's prn Trazodone and there was no duration date written for the prn Trazodone order. A review of the CP monthly drug regimen for Resident #6 revealed on 2/22/19, 3/22/19, and 4/29/19 there were no recommendations regarding the Trazodone prn order and the need	F 756	psychoactive medication for use in auditing these medications, both routine and PRN, for compliance with the 14 day stop date rule and/or documentation by the provider to substantiate the need to continue for a longer period. This review was completed on 5/17/19. The FNP was given a list of 3 residents who needed this documentation and asked to have it completed by 6/13/19. The Consultant Pharmacist was also made aware of the oversight during her review. C. To assure that residents who are administered psychoactive medications remain in compliance with this important safety regulation, new physicians orders will be reviewed for new orders daily during morning clinical review with the nursing leadership team beginning on 6/13/19. All new psychoactive medications will require a valid justification for use, a plan to monitor for efficacy as well as potential side effects. Also, a stop date to be written on the prescription. Each month the pharmacy audits medications for each resident in the facility. These pharmacy recommendations that concern the use of psychoactive medications will be brought to weekly risk meeting beginning in June, 2019. The interdisciplinary Risk team will review recommendations and determine the appropriate recommendation or request for the physician about discontinuing or continuing use as well as providing information about medication efficacy and potential side effects. The DON will review physicians orders on a	

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F 756	Continued From page 23 for documentation of the rationale to continue the prn order and there was no duration date written for the prn order. A telephone interview with the CP on 5/16/19 at 12:16 PM revealed she had conducted Resident #6's 1/27/19 and 3/22/19 medication regimen review. She stated she was aware of the CMS regulation for psychotropic prn medications and had made a recommendation to the prescriber on 1/27/19 for the need to document the rationale and indicate a duration date of the prn Trazodone order. The CP indicated she did not have any documentation in her notes as to why there was no follow up about this prn Trazodone. She further stated the CP who conducted the 2/22/19 medication regimen review was unavailable for an interview, but a review of her notes revealed she had not mentioned the prn Trazodone. The CP also stated she should have included this in the 3/22/19 medication regimen review. A telephone interview with the CP on 5/16/19 at 12:03 PM revealed she had conducted Resident #6's 4/29/19 medication regimen review. She stated it was the first time she had been to the facility and she had limited computer access to the electronic health records. She further stated she just missed notifying the practitioner of the need to document a rationale to continue the prn order and provide a duration date for the prn Trazodone. The CP indicated she was aware of the Centers for Medicare and Medicaid Services (CMS) regulation of the requirement for a duration date on psychotropic prn medications. An interview with the ANP on 5/16/19 at 12:40 PM revealed she was aware of the CMS regulation which required documentation of the rationale to	F 756	daily basis until each pharmacy consult has been addressed and order changes are written as appropriate. The DON will also be responsible to work with the Social Worker on monitoring behaviors that may be associated with psychoactive medication use. D. The DON will obtain report from pharmacy each month to determine which residents have orders for PRN psychotropic medications. The DON will review each resident's chart to ensure that the appropriate stop date was written and that the provider has documented the specific need for this medication. The initial audit was accomplished 5/17/19 by the DON. The audit tool used in clinical meeting will be brought to the monthly QAPI meeting by the DON. The facility will establish a benchmark for reducing the use of psychoactive medications as part of a QAPI effort. That data will be maintained and reviewed in QAPI monthly for one year. The DON is responsible for sustaining this corrective action which is fully implemented on 6/13/19. Completion date 6/13/19	

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F 756	Continued From page 24 continue a prn psychotropic medication and a duration date. She stated she had not documented the rationale to continue the Trazodone prn and had not written a duration date for Resident #6. She stated she had reviewed the medication regimen review dated 1/27/19 and had written a note on the form on 2/12/19 which stated she would document the rationale but forgot to do so. She stated it was just simple human error and she should have done it. An interview with the Director of Nursing (DON) on 5/16/19 at 12:55 PM revealed Resident #6 should have had a rationale documented and a duration date to continue the prn Trazodone. She further stated she was aware of the CMS regulation and this prn order should have been corrected to include a duration date. She stated that she received a copy of the monthly pharmacy review reports and thought this had been addressed. An interview with the Administrator on 5/16/19 at 12:55 PM revealed that Resident #6 should have had a rationale documented and a duration date to continue the prn Trazodone. She further revealed the DON gets a copy of the pharmacy reports and she should have reviewed them and ensured the recommendations were addressed.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following	F 758		6/13/19

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F 758	Continued From page 25	F 758		

categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be

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F 758	Continued From page 26 renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and adult nurse practitioner interview the facility failed to ensure physician's orders for a psychotropic medication, Trazodone, were time limited in duration for 1 of 4 residents reviewed for falls (Resident #6). Findings included: Resident #6 was admitted to the facility on 11/05/18 with diagnoses which included depression and anxiety. A review of the physician's order dated 12/31/18 indicated Trazodone (an antidepressant) 25 mg (milligrams) by mouth twice a day prn for aggression was ordered for Resident #6 by the adult nurse practitioner (ANP). There was no 14 day stop date written for this prn Trazodone order. A review of the ANP progress note dated 12/31/18 indicated Trazodone could be used up to twice a day to manage aggression and agitation and ordered a Psychiatric consult to assist with diagnosis and treatment of concurrent mental issues and dementia. A review of the Medication Administration Records (MARs) revealed per staff documentation on the MARs that Resident #6 had received 9 doses of prn Trazodone in January 2019, 2 doses in February 2019, and 4 doses in March 2019. Resident #6 was not	F 758	A. Use of psychoactive medications has potential for negative effects. Each resident may be prescribed such medications only with valid cause, with consideration for side effects, with a specified measure of efficacy and for the shortest duration possible to assess the need and value of the medication. Because Resident #6 hd not used PRN Trazodone in the month of April and May, the medication was discontinued on 5/16/19 due to non-use. B. All residents who are prescribed psychoactive medications have the potential to experience side effects. Based on a pharmacy report that details all psychoactive medications in use by residents, all residents were reviewed for their use. For each resident, a decision was made about the appropriateness of the purpose for use, the efficacy based on established metrics, the duration of use and a decision made as to whether or not to allow the medication to be continued. This review was conducted by the DON and nursing team on 5/17/19 with recommendations presented to the physician and/or FNP for evaluation. In the case that the medication would be continued the physician/FNP was asked to provide written justification for that continued use beyond the 14 day period of allowance. Based on review, the FNP	

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F 758	Continued From page 27 administered any prn Trazodone in April or May 2019. A review of ANP progress notes dated 2/19/19, 2/21/19, 2/28/19, 3/18/19, 4/8/19, and 5/2/19 did not include documentation of the rationale to continue the prn Trazodone. An interview with the ANP on 5/16/19 at 12:40 PM revealed she was aware of the CMS regulation which required documentation of the rationale to continue a prn psychotropic medication and a duration date for the prn Trazodone. She stated she had not documented the rationale to continue Resident #6's prn Trazodone and had not written a duration date. She indicated it was just simple human error and she should have done it. An interview with the Director of Nursing (DON) on 5/16/19 at 12:55 PM revealed that Resident #6 should have had a rationale documented and a duration date to continue the prn Trazodone. She further stated she was aware of the CMS regulation and this prn order should have been corrected to include a duration date. The DON stated there was a daily Interdisciplinary Team (IDT) meeting to review new orders and she did not know how the duration date had been missed on Resident #6's prn Trazodone order. An interview with the Administrator on 5/16/19 at 12:55 PM revealed that Resident #6 should have had a rationale documented and a duration date to continue the prn Trazodone. She confirmed there is a daily Interdisciplinary Team (IDT) meeting to review new orders and did not know how the duration date had been missed on Resident #6's prn Trazodone order.	F 758	was given a list of the 3 residents who needed this documentation for completion by 6/13/19. The Consultant Pharmacist was also made aware of the importance of alerting the nursing team when a medication might need additional review or reduction. C. Effective 6/13/19, all new orders for psychoactive medications, both scheduled and PRN are reviewed in clinical meeting each morning with the justification, potential side effects, measures of efficacy and duration of use clarified through the order review process. The review will require a stop date for the medication with a requirement for review to determine whether or not to continue the medication. If so, the provider will draft a written justification for the clinical record. The Consultant Pharmacist report will be reviewed by DON, nursing leadership and potentially the At Risk meeting team, each month to address findings and recommendations with the objective of limiting use to only those medications which are effective and can be safely administered, are not part of multiple medications being administered for the same purpose, are at the lowest dose effective and for the shortest duration possible. These meeting recommendations and findings will be documented on a psychoactive audit tool by the DON. D. The audit tool of findings will be brought to monthly QAPI beginning with the June, 19 meeting for the purpose of	

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F 758	Continued From page 28	F 758	review by the QAPI committee whose goal of reaching a benchmark of reduced use over the next 12 months will be measured by the reduction for use without negative consequences for residents. The DON is responsible for sustaining compliance with this corrective action which will be fully implemented by 6/13/19. Completion date 6/13/19.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to date potentially hazardous food	F 812	A. (1)All opened, undated, and outdated food items in the kitchen's walk-in cooler	6/13/19

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F 812	Continued From page 29 after opening and failed to remove expired food from 1 of 1 walk-in coolers, failed to label and date food in 1 of 2 nourishment room refrigerators, and failed to clean 1 of 2 facility ice machines. The findings included: 1. An initial observation of the kitchen's walk-in cooler on 05/13/19 at 9:49 AM revealed an 80 ounce container of pre-made chicken salad that was dated as being opened on 05/07/19 and was available for use, an open and undated 80 ounce container of pre-made chicken salad available for use, a tray of 5 undated chicken salad croissants available for use, an open and undated 80 ounce container of pimiento cheese available for use, and an undated pot of melted butter available for use. An interview with the Dietary Manager on 05/13/19 at 9:55 AM revealed she expected open containers of food to be dated when opened. The Dietary Manager stated she did not know when the opened and undated containers of chicken salad and pimiento cheese were opened. The Dietary Manager stated the opened chicken salad dated 05/07/19 was good for 3 days after being opened and should have been discarded on 05/12/19. The Dietary Manager stated the chicken salad croissants were made from one of the open containers of chicken salad. The Dietary Manager stated the pot of melted butter should have been dated. An interview with the Administrator on 05/16/19 at 1:40 PM revealed she expected food to be labeled and dated when it was opened. The Administrator stated if the Dietary Manager stated	F 812	were discarded on 5/13/19. Unlabeled and undated food in the nourishment room refrigerators on A Hall were discarded. (2) The ice machine on A unit was santizied per facility policy on 5/20/19. The requirement for Hairnets and facial hair nets were immediately enforced. B. All residents have the potential to be affected by this deficient practice. C. (1)An in-service was held with all dietary staff on 5/14/19 and 5/15/19 to include instructions to mark all food products as they are received with the date of expiration. They are further instructed that each food item is then dated when opened with an opened date at the time the seal is broken. Dietary staff were also instructed to discard any opened unused containers or those with a date of more than 3 days old. Instruction included that Foods may not be kept beyond their expiration date and no food is to be kept without a valid date. The nutritional services manager is responsible to enter and examine all food products on a daily basis assuring that no food is unmarked, improperly stored or kept beyond its appropriate use date. Dietary staff was in-serviced on 5.14.19 for the required use of hair nets as well as facial hair nets 2) The administrator will spot check the food storage areas and the freezers as well as to monitor the nourishment room refrigerators at random no less than 3X per week with data being collected on an	

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F 812	Continued From page 30 the chicken salad was only good for 3 days after being opened it should not have been available for use. 2. An observation of the A hall nourishment room refrigerator on 05/13/19 at 12:08 PM revealed the refrigerator contained an unlabeled and undated 32 ounce container of coffee creamer, an unlabeled and undated container of French fries, and an unlabeled and undated bag containing 2 biscuits. An interview with the Dietary Manager on 05/13/19 at 12:35 PM revealed she was not sure who was responsible for discarding unlabeled and undated food in the nourishment room refrigerators. An interview with the Director of Nursing (DON) on 05/13/19 at 2:28 PM revealed since the nursing staff usually placed resident food from home in the nourishment room refrigerators it was their responsibility to label and date the food. The DON stated all outside food should be discarded after 72 hours. An interview with the Administrator on 05/16/19 at 1:40 PM revealed she expected food stored in the nourishment room refrigerators to be labeled and dated. 3. An observation of the A hall nourishment room's ice machine on 05/13/19 at 12:10 PM revealed a brown substance on the water condenser and ice tray. An interview with the Maintenance Director on 05/13/19 at 12:28 PM revealed the ice machine was supposed to be cleaned quarterly and the	F 812	audit tool. (2)All dated and unlabeled food items in nourishment refrigerator on A wing where discarded. 5/13/19 by the dietary manager. The housekeeping staff is now responsible as of /13/19 for checking each nourishment room refrigerator on a daily basis and discarding any foods that are greater than 3 days old or that are not dated. Nursing staff were in-serviced on 5/13/19 and 5/14/19 by the Staff Development Coordinator to inform the staff of their responsiblity to date and lable, with the resident's name, all food items that where placed in the refrigerator. Staff were also instructed that staff members were not to use the nourishment refrigerator for personal itmes. As a back up, night shift (11pm-7am) charge nurse was inserviced on 5/14/19 to assign a staff member to inspect the nourishment refrigerators each night on both A Hall and B Hall units for food that was undated, and or with no identifying name of a resident. Foods without dates or older than 3 days were to be discared as were foods without an identifying resident's name. Charge nurse will document his/her findings taken nightly. In-service conducted by SDC. Documentation of daily check of refrigerators on A and B Hall are on the refrigerators and put in place on 6/10/19. All staff on 6/12/19 were in-serviced once again and shown the tool and what should be filled out. (3) Ice machines on each unit have been sanitized on 5/17/19 and are placed on a monthly preventive maintenance schedule for sanitizing and on a weekly check sheet to assure there	

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F 812	Continued From page 31 brown substance on the ice machine condenser and ice tray should not be there. The Maintenance Director stated he was not sure when he last cleaned the ice machines. A subsequent interview with the Maintenance Director on 05/13/19 at 1:05 PM revealed he had not cleaned the ice machine since August 2018. The Maintenance Director stated prior to the ice machine being cleaned in August 2018 by him an outside company cleaned the ice machine and they last cleaned the ice machine February 16, 2018. The Maintenance Director stated he had not been trained in the correct way to run chemicals through the ice machine and he did the best he could when he cleaned it in August 2018. The Maintenance Director stated he had been really busy and had not gotten around to trying to clean the ice machine since last August. An interview with the Administrator on 05/16/19 at 1:40 PM revealed she expected the ice machine to be clean. The Administrator stated she was not sure what the cleaning schedule was for the ice machines.	F 812	is not evidence of contamination. D. (1) The DON will make daily rounds x 1 month to ensure that all items in nourishment refrigerators are dated and labeled appropriately. The DON will review the documentation on 11-7 charge nurse daily x 1 month and then 2 times weekly for 3 months then once a week for 3 month to ensure nightly inspection and approriate actions have been taken and are recorded on the audit tool effective 6/13/19. Reports will be taken to monthly QAPI meetings by the DON. (2) Hairnets/beardnets will be monitor by Dietary Manager daily for 30 days. They will continue to be monitored by Dietry Manager through weekly monitoring and in place by 6/13/19 Reports will be presented at monthly QAPI meetings. (3) All food coolers must have an open date/use by date. This will be monitored by Dietary Manager daily for 30 days and recorded and then by Dietary Manager on weekly basis on going. This in place by 6/13/19 and will pbe presented at monthly QAPI meetings. (4) The Maintenance Director will present monthly rounds that include the ice machine monitoring and state date it is to be next cleaned at the monthly QAPI meeting. The Administrator is responsible for sustaining compliance with this corrective action which is fully implemented by 6/13/19.	
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4)	F 814		6/13/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN HOME HEALTH AND REHAB	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

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F 814	Continued From page 32 §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure the dumpster lid was closed and the area around the dumpster was free of debris for 1 of 3 dumpsters. Findings included: During the tour of the dumpster area on 05/13/19 at 9:49 AM with the Dietary Manager observations revealed dumpster #1 (a cardboard dumpster) was so full the lid of the dumpster would not close and 3 cardboard boxes were visible on the ground around dumpster #1. The Dietary Manager stated Maintenance was responsible for keeping the dumpster area clean. An interview with the Administrator on 05/13/19 at 10:15 AM revealed the company that picks up regular trash came on Friday but she was not sure when the company that emptied the cardboard was scheduled to come. The Administrator stated there should not be debris on the ground around the dumpsters and the lid should be closed on dumpster #1. The Administrator stated Maintenance was responsible for keeping the area around the dumpsters free of debris. An interview with the Maintenance Director on 05/13/19 at 11:59 AM revealed it was the responsibility of the Maintenance Department to keep the area around the dumpsters free of debris. The Maintenance Director stated dumpster #1 was usually emptied weekly and he	F 814	A. (1) The trash dumpsters are emptied on Monday, Wednesday and Friday. The cardboard dumpster is emptied on Wednesday. (2) The CEO spoke witht he director of the Sanitation Co. and confirmed the picking up of the cardboard should have been Wednesday the prior week. He was apologetic and could give no explanation as to why it was not picked up. The cardboard dumpster was emptied on 5/15/19. B. All residents have the potential to be affected by this deficient practice. C. The Maintenance Director will inspect the dumpster area on a daily basis to ensure pick up of cardboard is occurring and that items around the dumpster is picked up and placed in the appropriate dumpster to keep area clean. He will promptly inform CEO should there be a delay in this service. This began 5/20/19. D. The CEO will inspect the dumpster area weekly to ensure trash and cardboard pick up are occurring as scheduled. This began on 5/20/19. It will be monitored though the QAPI monthly meetings.	

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F 814	Continued From page 33 was not sure when the next pick up date was scheduled.	F 814		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0382	A. BUILDING: _____ B. WING _____	05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN HOME HEALTH AND REHAB	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

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L 040	.2209(A) INFECTION CONTROL 10A-13D.2209 (a) (a) A facility shall establish and maintain an infection control program for the purpose of providing a safe, clean and comfortable environment and preventing the transmission of diseases and infection. This Rule is not met as evidenced by: Based on record review and staff interviews, the facility failed to have a designated staff member who was responsible for infection control complete a course in an approved program for infection control. The findings included: On 05/16/19 at 2:28 PM an interview was conducted with the Staff Development Coordinator (SDC) who confirmed she was designated staff member in charge of infection control for the facility. The SDC stated she had not attended a course in an approved program for infection control and was not currently registered to attend a course. She added there was currently no staff member in the facility who had received the required infection control training. On 05/16/19 at 2:55 PM an interview was conducted with the Administrator who stated she was aware of the state regulation and explained they were currently in transition with a new corporation. She confirmed there were no staff currently in the facility who had attended a course in an approved program for infection control and the 2 staff members who had received the required training both left in February 2019. She added they planned for the new Assistant Director	L 040	A. On 6/1/19 Karen Rowan became employed at this facility and is Spice Certified. B. We will send qualified person/persons to be trained and the first training is set up for 10/28-10/30 2019 and registration is not until 7/15/2019. C. During the hiring process for SDC/infection control will check for SPICE certification and if not see that person is set up with the 10/28-10/30 session that is not available for registration until 7/15/19. This will be in effect by 6/13/19. D. The CEO and DON will check monthly to report to QAPI that there is a SPICE certified person and if not that some training is set up or being set up for that person. This will be ongoing to insure compliance. POC completed by 6/13/2019	6/13/19

Division of Health Service Regulation

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

Electronically Signed | 06/07/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0382	A. BUILDING: _____ B. WING _____	05/16/2019

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L 040	Continued From page 1 of Nursing, who would be starting in 2 weeks, to attend the required course in infection control but she had not yet been registered to attend a course.	L 040		