STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING _____ B. WING _____	C 07/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL AT WINSTON SALEM	1900 W 1ST STREET WINSTON-SALEM, NC 27104

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E 000	Initial Comments An unannounced recertification and complaint survey was conducted 721/19 through 7/25/19 and 7/29/19. The facility was found in compliance with the requirement CFR 488.73, Emergency Preparedness. Event ID ZYQJll.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint survey was conducted 721/19 through 7/25/19 and 7/29/19. The facility provided additional information via email on 7/29/19	F 000		
F 568 SS=D	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident, family and staff interviews, the facility failed to provide 2 of 2 residents (Resident #2 and Resident #9) or their representative with quarterly statements of their personal trust fund account managed by the facility. The findings included: The facility was representative payee for 105	F 568	F 568 Accounting and Records of Personal Funds " Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice	8/22/19

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

Electronically Signed | 08/22/2019

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F 568	Continued From page 1 residents who resided in the facility. 1.Record review of the "Social Security Administration Retirement, Survivors and Disability Insurance" letter dated April 3, 2018 on behalf of Resident #2 acknowledged the facility as resident's representative payee. Interview on 07/21/19 at 3:53 PM with Resident #2 and responsible representative was conducted. Both stated they had not received quarterly statements since the facility managed Resident's #2 personal funds. Interview with the current Business Office Manager #1 (BOM) on 7/22/19 at 2:44 PM stated the facility's corporate office managed residents' personal funds. Review of the email dated 7/22/19 at 3:02 PM from a representative from the corporation that managed the facility's finances (CMF) stated "One [referring to a quarterly statement] was generated for 4/19. I would assume it was sent." This email was unclear as to when the statement had been originally sent to the business office at the facility. Interview via the phone on 7/22/19 at 3:18 PM with a previous BOM #2 (who was employed from 4/3/19 to 6/29/19 stated "I never sent any quarterly statements" to the resident or representative. Interview on 7/22/19 at 3:26 PM via the phone with CMF representative stated the facility staff was responsible for providing the quarterly statement to the residents or representative.	F 568	Resident # 2 was issued a quarterly statement on 07/31/2019 Resident # 9 was issued a quarterly statement on 07/31/2019 " Address how the facility will identify other residents having the potential to be affected by the same deficient practice; 1. No residents were harmed as a result of the deficient practice. All residents with a facility resident trust account or their representative have received a current trust statement as of 08/22/2019 for the months of May, June, July. 2. Current residents with a facility resident trust account have the potential to be affected by the deficient practice, thus the following corrective actions have been taken; as a means to ensure ongoing compliance the Business Office Manager was re-educated on 07/30/2019 on the facility's Policy and Procedure regarding Resident's Trust and quarterly statements by the facility administrator " The monitoring processes and systemic changes to ensure plan of	

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F 568	Continued From page 2 Interview on 7/25/19 at 8:24 AM via the phone with BOM #3 (previous BOM worked at the facility from 8/20/14-4/30/19) stated quarterly statements are obtained via a computerized program and she always sent quarterly statements to residents or representatives. " I have no way to prove that I sent them." Interview on 07/25/19 at 12:43 PM with the administrator stated his expectation was every resident or family representative the facility handled personal funds should receive a quarterly personal fund statement. 2.Interview on 7/21/19 at 2:20 PM with the responsible representative of Resident #9 stated he nor the resident never received an account statement. Interview with the current Business Office Manager #1 (BOM) on 7/22/19 at 2:44 PM stated the facility's corporate office managed residents' personal funds. Interview via the phone on 7/22/19 at 3:18 PM with a previous BOM #2 (who was employed from 4/3/19 to 6/29/19 stated "I never sent any quarterly statements" to residents or representatives. Interview on 7/22/19 at 3:26 PM via the phone with CMF representative stated the facility staff was responsible for providing the quarterly statement to the residents or representatives. Interview on 7/25/19 at 8:24 AM via the phone with BOM #3 (previous BOM worked at the facility from 8/20/14-4/30/19) stated quarterly statements are obtained via a computerized	F 568	correction is effective: 1. On 08/22/2019 the business office manger was re-educated on the process of issuing quarterly statements of personal trust fund accounts to include an initial line upon receipt or a copy of the envelope that is addressed to the resident representative and the notation will be put in a log and kept in the business office. 2. A log will be maintained by the business office manager to include a list of all current residents that the facility is Rep Payee and this log will include notations of when quarterly statements are received and when they are mailed to the resident and or resident representative 3. The administrator will review the log quarterly to ensure it is completed with all notations to ensure statements are mailed timely 4. Monitoring to ensure solutions are sustained the Administrator will audit residents' quarterly statements signing off statements have been printed and mailed every quarter for one year starting the (third) quarter of 2019 resident's statements which will go out 10/31/2019 for the Months of August, September, October. " Indicate how the facility plans to monitor its performance to make sure that	

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F 568	Continued From page 3 program and she always sent quarterly statements to residents or representatives. " I have no way to prove that I sent them." Interview on 07/25/19 at 12:43 PM with the administrator stated his expectation was every resident or family representative the facility handled personal funds should receive a quarterly personal fund statement.	F 568	solutions are sustained 1. The administrator will present the results of the reports and a copy of the log to the Quality Assurance performance improvement committee (QAPI) quarterly for 12 months for any recommendations or modification. 2. The plan of correction will be submitted by Administrator to the Quality Assurance performance improvement Committees and the results of the audits will be reviewed quarterly for 12 months and become a topic of the Monthly Quality Assurance Committee meeting to ensure that compliance is sustained. 3. The QAPI committee can modify this plan to ensure a facility remains in compliance.	
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	F 584		8/26/19

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F 584	Continued From page 4 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); §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 resident interviews, staff interviews and observation the facility failed to (1) maintain floor tiles in the resident room, resident bathrooms, dining room and hallways, (2) maintain walls in good repair, (3) maintain a bedside table and cabinet in good repair (4) maintain a clean elevator floor and elevator tracks that are clean and in good repair, (5) maintain clean equipment in resident rooms, (6) maintain clean and paint chipped free handrails, (7) maintain clean windows in the dining room. This was evident in 1 of 4 resident care units (Unit 200). Findings included:	F 584	F 584 Safe/Clean/Comfortable/Homelike Environment " Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice 1. Room 216 A / resident # 23 room floor tiles and bathroom floor tiles were cleaned and dark brown substance was removed from the corners on 08/01/2019 2. Room 206 B resident # 82 floor tiles in room and bathroom were cleaned on 08/01/2019 3. Room 204 Floor tiles were cleaned on	

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F 584	Continued From page 5 1a.Observation on 7/21/19 at 1:37 PM revealed the corners of the floor tile in both elevators (service elevator and #1 elevator) had an accumulation of a dark brown substance. There was missing floor tile in #1 elevator. 1b.Observation in Room 216A on 7/21/19 at 1:40 PM revealed floor tiles in the resident room and bathroom had an accumulation of a dark brown substance within the corners. In addition, the bathroom floor tiles were soiled with a dark brown colored substance. Behind the door in the resident room was an accumulation of dust and trash. During this observation Resident #23 stated our rooms were not cleaned on yesterday (referring to 7/20/19). Observation on 7/22/19 at 11:55 AM revealed no change in the environment of Room 216. 1c.Observation in Room 206 B on 7/21/19 at 2 PM revealed the floor tiles in the resident room and the bathroom were stained. Resident #82 indicated the room had not been cleaned on yesterday (referring to 7/21/19). 1d.Observation in Room 204 on 7/21/19 at 2:05 PM revealed the floor tiles in the resident room had an accumulation of a dark substance in the corners. The perimeter at the base of the commode had a buildup of a red and brown colored substance. Two (2) silver colored soap holder attached to the wall had a white colored dry substance on the surface. 1e.Observation in Room 214 on 7/21/19 at 2:10 PM revealed the corners in the resident room and bathroom had an accumulation of a brown colored substance. 1f.Observation in Room 202 on 7/21/19 at 2:12	F 584	08/01/2019, base of the toilet was cleaned on 08/01/2019 and the two soap holders were cleaned on 08/01/2019 4. Room 214 Corners of the room and bathroom were cleaned on 08/01/2019 5. Room 202 Room floor tiles were cleaned on 08/03/2019 and base of commode was cleaned on 08/03/2019 6. Unit 200 the hall floor tiles were cleaned on 07/24/2019 the cove base along the 200 unit hallway was cleaned on 07/24/2019. 7. Unit 200 Dining room floor tiles were cleaned on 07/26/2019 8. Room 228 floor tiles were cleaned on 07/26/2019 9. Room 201 Bathroom tiles around commode were cleaned on 07/26/2019 10. Room 212 Floor tiles and around the sink were cleaned on 07/24/2019 11. Room 207 toilet seat was replaced on 07/23/2019. Bathroom and floor tiles were cleaned on 07/24/2019 12. Unit 200 the floors were cleaned behind the doors of dust and trash on 07/24/2019 13. Room 208 Bathroom and base of commode were cleaned on 07/24/2019 14. Room 216 Ceiling was cleared of peeling paint, cove base replaced, peeling wall paper was removed, and the plaster on the wall was repaired on 07/23/2019 15. Outside room 411 handrails have been cleared of chip paint on 08/26/2019 16. Room 206 Over bed table has been replaced on 07/23/2019 17. Room 214 Bedside table has been replaced on 07/25/2019. Cabinet has been cleared of chip paint on 08/22/2019	

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F 584	Continued From page 6 PM revealed the resident room floor tiles were soiled, the floor tiles in the bathroom around the base of the commode was heavily stained with a red colored substance. 1g.Observation of the 2nd floor on 7/21/19 at 2:20 PM revealed the floor tiles on the long hallway were cracked with a buildup of a brown colored substance at the edge of the cove molding. 1h. Observation of the 2nd floor dining room on 7/21/19 at 2:25 PM revealed the floor tiles at the entrance into the dining room had an accumulation of brown colored substance in the corners. 1i.Observation on 7/21/19 at 2:37 PM revealed the floor tiles in the hallway near Room 219 were stained with an accumulation of a brown colored substance near the cove molding, 1j.Observation on 7/21/19 at 2:39 PM revealed Resident room #228 had floor tiles that were soiled with an accumulation of a brown colored substance. 1k.Observation on 7/22/19 at 11:58 AM revealed no change of the environment in the 2nd floor dining room. Observation on 7/22/19 at 5:50 PM revealed no change in the dining room on the 2nd floor. 1l.Observation on 7/22/19 at 11:35 AM in Room 201-bathroom tiles around the base of the commode had an accumulation of red and brown colored substance. 1m.Observation of 7/22/19 at 11:40 AM in Room	F 584	18. Elevator number 1, tracks were cleaned on 07/24/2019 the holes in the cove base repaired on 08/26/2019 peeling paint upon entrance to elevators removed on 08/26/2019 19. Room 200 tube feeding pump was cleaned on 07/24/2019 20. Unit 200 Dining room windows were cleaned and cob webs removed on 07/24/2019 21. Dangling blue cord across from second floor elevator was secured on 08/22/2019 22. Unit 200 handrails were cleaned 07/24/2019 and cleared of peeling paint on 08/26/2019 " Address how the facility will identify other residents having the potential to be affected by the same deficient practice; 1. A 100% audit of current resident rooms was completed by the maintenance director and Administrator on 08/22/2019 . Any areas of concern were placed in the work order book for the Maintenance team or housekeeping team to address timely. " The monitoring processes and systemic changes to ensure plan of correction is effective 1. The Maintenance Director and	

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F 584	Continued From page 7 212 the bathroom floor tiles had an accumulation of a brown colored substance in the corners and under the sink. 1n. Observation on 7/22/19 at 11:45 AM revealed floor tiles in the hallway near Room 204 were cracked. 1o.Observation on 7/22/19 at 11:50 AM revealed in Room #207 had a cracked toilet seat. The bathroom and resident room floor tiles had an accumulation of a brown colored substance. 1p. Observation on 7/22/19 at 5:45 PM witnessed by Housekeeper/Laundry (HL)#3 revealed an accumulation of trash, dirt and a plastic medication cup were on the floor behind the fire door near Room 200. Additionally, there was a brown colored stain in the hallway across from the nurses' station. Interview with HL #3 during the observation revealed he previously was the floor technician but now was working in laundry and could not respond to the status of the environment. 1q. Observation on 07/23/19 at 7:58 AM revealed the bathroom floor tile in Room 208 around the base of the commode had a red colored stain. 2a.Observation on 7/21/19 at 1:37 PM revealed the entrance to each elevator had chipped paint. 2b. Observation of Room 216A on 7/21/19 at 1:40 PM revealed a peeling ceiling, missing cove molding, crumbling plaster on the wall near the bathroom entrance, multiple black marking across the wall and peeling wall paper. Observation on 7/22/19 at 11:55 AM revealed no change in the environment of Room 216. 2c. Observation on 7/23/19 at 4:20 PM revealed chipped paint on the handrails near Room 411.	F 584	Maintenance Assistant were educated by the administrator on 08/01/2019 about the importance of Maintenance services to maintain a sanitary, orderly, and comfortable interior. The Housekeeping supervisor was re-educated by the district housekeeping supervisor on 08/13/2019 about the expectation of daily cleaning and deep cleaning task. Current facility staff will be educated by 08/13/2019 on the importance of writing work orders in the maintenance books daily for Maintenance to address any safety concerns. The monitoring processes and systemic changes to ensure plan of correction is effective " Indicate how the facility plans to monitor its performance to make sure that solutions are sustained 1. A Facility Environmental Rounds Tool will be used by the assigned department heads to include maintenance director, nursing mangers, housekeeping supervisor and activity personal to monitor resident rooms in addition to hallways and dining rooms to ensure resident rooms and hallways are kept clean along with completing repairs timely. These rounds will be completed 5 times a week for 12 weeks 2. Director of nursing will visually inspect tube feeding pumps weekly for 12 weeks to ensure these items are cleaned and	

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F 584	Continued From page 8 3a.Observation in Room 206 B on 7/21/19 at 2 PM revealed the veneer was missing on the overbed table. 3b.Observation in Room 214 on 7/21/19 at 2:10 PM revealed the plastic veneer was peeling off the bedside table and bedside cabinet. 4a. Observation on 7/21/19 at 1:37 PM revealed the tracks of the #1 elevator and the service elevator had an accumulation of dust, dirt and trash. Observation on 7/22/19 at 11:15 AM revealed the tracks of both elevators remained soiled. Both elevators had holes in the cove molding. Observation on 7/22/19 at 5:10 PM and 7/23/19 at 9:05 AM the tracks and inside both elevators remained unchanged. 5a. Observation in Room 200 on 7/21/19 at 2:18 PM revealed the front of enteral feeding pump and stand had a dried beige colored splatter that resembled tube feeding formula. 5b. Observation on 7/22/19 at 5:55 PM revealed a dangling blue cord across from the 2nd floor elevator. Observation of the second-floor environment and interview on 7/22/19 at 6:15 PM with Regional Manager (RM) of the facility contracted housekeeping services revealed the status of the floor tiles, dining room, bathroom tiles, furniture , elevators, elevator tracks and enteral feeding pumps and poles remained unchanged. During the interview. RM stated the housekeeping contract started on 7/1/19 after the facility was newly acquired and was in the process of hiring additional staff.	F 584	without visible debris. 3. The administrator will present the results of the audit tools to the Monthly Quality Assurance Performance Committee monthly for 3 months and they will determine the need for recommendations or modification. The regional environmental services consultant will visit and round with the administrator and environmental services supervisor to ensure that the facility remains clean. 4. Second, Third, fourth, and fifth floors will be stripped by 08/26/2019. Deep cleaning does include cleaning the floors and removing any dirt or dust from the areas. Over bed tables and bedside table will be audited during each deep clean and replaced as needed. Environmental services continues to hire personnel to ensure residents have a clean and healthy environment in which to live.	

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F 584	Continued From page 9	F 584		

6. Observation of the 2nd floor on 7/21/19 at 2:20 PM revealed paint on the handrails were peeling. The space between the handrail and wall had an accumulation of dust, dirt, paper and a plastic spoon.

Observation on 7/22/19 at 5:58 PM revealed the space between the wall and handrail continued to have paper, a spoon, dust and dirt present

7. Observation of the 2nd floor dining room on 7/21/19 at 2:25 PM revealed there were windows with multiple dark brown and black colored cobwebs.
Observation on 7/22/19 at 11:58 AM revealed no change of the environment in the 2nd floor dining room.
Observation on 7/22/19 at 5:50 PM revealed no change in the dining room on the 2nd floor.

Interview on 07/23/19 at 9:36 AM with the Housekeeping Manager (HM) stated she was short of staff on 7/21/19 due to staff resignations on Friday (7/20/19) and staff call outs. Continued interview with the HM stated she was in the process of hiring and training staff. HM stated "I am understaffed, and HK was responsible for the cleaning of enteral feeding pumps and poles and expected the residents have a clean free environment.

Interview on 07/23/19 at 10:28 AM with HK#4 (who worked on 7/21/19) stated the 2nd and 3rd floors were short staffed, and no one was scheduled to work the long hallway on 2nd floor so only the overflowing trashcans in resident rooms were removed.

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F 584	Continued From page 10 Interview with the Maintenance Director (since 6/18/19) on 7/23/19 at 10:49 AM revealed there was a lot of work to be completed with 2 staff members. Interview on 7/25/19 at 12:16 PM with the Administrator, Regional Nutritional Consultant, and Regional Director of Operations (RDO) was conducted. The Administrator stated the recently changed housekeeping contract services, lack of HK staff, leadership transition, and the elevator breakdown lead to some of the issues with the environment. The RDO stated the facility would be renovated under the new ownership. The Administrator stated his expectation for the building was to be clean, the nurses' responsibility under the direction of the Director of Nurses was to have the enteral feeding pump clean and HK was to clean the base of the feeding pole.	F 584		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by:	F 637		8/22/19

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F 637	Continued From page 11 Based on record review and staff interviews, the facility failed to identify a significant change in status for 1 of 5 residents reviewed for unnecessary medications (Resident #37). Findings included: Resident #37 had been admitted on 9/18/17. Diagnoses included Chronic Obstructive Pulmonary Disease (COPD), Schizophrenia, Bipolar, Anxiety and Depression. A physician note dated 6/7/18 indicated Resident #37 was to continue her medications as prescribed and was stable on the current dose. Resident #37's annual Minimum Data Set (MDS) assessment dated 10/25/18 indicated she had severe cognitive impairment, was frequently incontinent, required supervision with walking, locomotion and eating. She required extensive assistance with bed mobility, transfers, dressing, toileting, hygiene and bathing. Resident #37's Quarterly MDS assessment dated 2/21/19 indicated she had moderate cognitive impairment, was always incontinent, she did not walk, required total assistance with dressing, toileting, hygiene and bathing. On 7/22/19 at 4:06 PM Resident #37 was observed lying in bed. An interview was attempted, and she was able to indicate she was uncomfortable. The call bell was within reach and she was able to activate it with verbal cues. Staff arrived within a few minutes to reposition Resident #37. On 7/23/19 at 11:36 AM an interview with the 300-hall unit manager was conducted. She stated when Resident #37 had been first admitted, she had been more alert and was able to walk with a walker. The Unit Manager further stated Resident #37 had declined since admission. She	F 637	F 637 Comprehensive Assessment After Significant Change " Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice 1. Resident # 37 significant change assessment completed and transmitted on 08/01/2019 " Address how the facility will identify other residents having the potential to be affected by the same deficient practice; An MDS audit of the most recently completed MDS will be completed on current residents to determine if any significant are required by the MDS coordinators on 08/22/2019. Any significant changes identified will be placed on the MDS schedule to have a Significant change assessment MDS completed. " The monitoring processes and systemic changes to ensure plan of correction is effective 1. On 07/25/2019 , MDS nurse #1 , #2 and # 3 were in-serviced by the Regional	

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F 637	Continued From page 12 stated Resident #37 was alert but not completely oriented, could make her needs known, and required total care for most of her Activities of Daily Living (ADLs). On 7/24/19 at 9:32 AM Resident #37 was observed sitting up in bed, eating breakfast. An interview was attempted, and she only indicated that she had no concerns. On 7/24/19 at 12:14 PM an interview with the MDS Nurse #1 was conducted. The nurse stated she had reviewed the documentation and a significant change in status assessment had been missed. The nurse further stated that a significant change in status assessment should have been completed as Resident #37 had declined in several areas. On 7/25/19 at 10:09 AM an interview with the Administrator was conducted. He stated it was his expectation for the MDS assessments to be correct and if a change in condition had occurred, it should be addressed.	F 637	MDS Nurse Consultant regarding the guidelines used to determine whether a significant change assessment is required. 2. Effective 08/22/2019 , to ensure the alleged practice does not recur include: In clinical meeting (Monday-Friday) both MDS nurses and morning clinical team will evaluate and compare current MDS that is being completed to the previous MDS to determine if a significant change has occurred. 3. The daily 24 hour report will be reviewed by the Director of Nursing and MDS Coordinators Monday- Friday to determine if a resident has had a change in status that would warrant a significant change in regards to MDS. " Indicate how the facility plans to monitor its performance to make sure that solutions are sustained 1. Effective 08/22/2019, MDS #1 and MDS #2 along with MDS #3 will alternate on each other□s assessments by conducting ten random audits per week x□s 4 weeks then monthly x 3 months. If a significant change has occurred, the resident will be scheduled for a significant change assessment. Results will be	

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F 637	Continued From page 13	F 637	presented at the monthly Quality Assurance meeting x 3 months and documented on the Significant Change Tool.	
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 observations, record review and resident and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) for 1 of 1 resident reviewed for indwelling urinary catheter (Resident #91), for 1 of 5 residents reviewed for unnecessary medications (Resident #37), and 1 of 8 residents reviewed for Activities of Daily Living (Resident #150). Findings include: 1. Resident #91 had been admitted on 10/31/18. Her diagnosis included neurogenic dysfunction, paraplegia and chronic pain. Resident #91's care plan indicated she had bladder incontinence related to paraplegia and had a history of a urinary catheter that had malfunctioned and was unable to be reinserted. a. Resident #91's Quarterly MDS dated 1/30/19 indicated she was cognitively intact and used an indwelling urinary catheter and her urinary continence was not rated due to use of a catheter. b. Resident #91's Quarterly MDS dated 6/6/19 indicated Resident #91 was cognitively intact used an indwelling urinary catheter and was always incontinent of urine.	F 641	F 641 Accuracy of Assessments " Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice 1. Resident # 91 1/30/19 MDS was modified to indicate no catheter and transmitted on 07/26/2019 2. Resident # 37 2/21/19 and 4/25/19 MDS were modified to indicate the correct date for Gradual dose reduction contraindication and transmitted on 07/26/2019 3. Resident #150 4/17/19 MDS was modified to indicate the correct coding for ADL□s and transmitted on 08/22/2019 " Address how the facility will identify other residents having the potential to be affected by the same deficient practice; 1. Section H0100, H0300, G0110, G0120 and N0450 of the most recently completed MDS, for all current residents, will be audited for accuracy by the MDS Coordinators #1-3. Modifications if	8/22/19

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F 641	Continued From page 14 On 7/22/19 at 9:45 AM an interview with Resident #91 was conducted. She stated prior to admission, she had used a suprapubic catheter and had developed problems with it. She stated she does not have a catheter and leaks urine through the suprapubic fistula which is managed with adult briefs and towels. On 7/23/19 at 12:15 PM an interview was conducted with the 400-hall unit manager. She stated Resident #91 had not had an indwelling urinary catheter since before admission. On 7/24/19 at 12:14 PM an interview with the MDS Nurse #1 was conducted. The nurse stated these assessments had been coded incorrectly for indwelling urinary catheter. She further stated the nurse should have verified this information. On 7/25/19 at 8:01 AM an interview was conducted with a Nurse Aide (NA) who regularly cared for Resident #91. She stated Resident #91 had not had an indwelling urinary catheter since admission. The NA further stated Resident #91 leaked urine, and this was managed with adult briefs and towels. On 7/25/19 at 10:09 AM an interview with the Administrator was conducted. He stated it was his expectation for the MDS assessments to be correct. 2. Resident #37 had been admitted on 9/18/17. Her diagnoses included Schizophrenia, Bipolar, Anxiety, Depression, and Chronic Obstructive Pulmonary Disease (COPD). A physician note dated 6/7/18 indicated Resident #37 was to continue her medications as prescribed and was stable on the current dose. An attempt or reduction in the doses would cause decompensation of Resident #37 a. Resident #37's Quarterly MDS assessment dated 2/21/19 indicated she had moderate	F 641	needed will be corrected and submitted by the MDS coordinators. 2. MDS staff, will be re-educated by the Regional MDS consultant on 07/25/2019 regarding the importance of accurately coding the MDS, specifically, section H0100, H0300, G0110, G0120 and N0450 " Measures/Systematic changes put in place to ensure that the deficient practice does not reoccur: 1. Regional MDS consultant and MDS coordinators will audit section H0100, H0300, G0110, G0120 and N0450 of 5 Minimum data sets per week x 12 weeks to ensure accuracy. After the 12 weeks the regional MDS consultant and MDS coordinators will review section H0100, H0300, G0110, G0120 and N0450 of random completed MDS□s during visits to ensure the facility maintains compliance " Indicate how the facility plans to monitor its performance to make sure that solutions are sustained 1. Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance and Performance Improvement Committee by MDS coordinator monthly x 3 months. At that time, the Quality Assurance and Performance	

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F 641	Continued From page 15 cognitive impairment and a Gradual Dose Reduction (GDR) has been documented by the physician as clinically contraindicated on 7/16/18. b. Resident #37's Quarterly MDS assessment dated 4/25/19 indicated she had moderate cognitive impairment and a Gradual Dose Reduction (GDR) had not been documented by the physician as clinically contraindicated. On 7/22/19 at 4:06 PM Resident #37 was observed lying in bed. An interview was attempted, and she was able to indicate she was uncomfortable. The call bell was within reach and she was able to activate it with verbal cues. Staff arrived within a few minutes to reposition Resident #37. On 7/24/19 at 12:14 PM an interview with the MDS Nurse #1 was conducted. The nurse stated she had reviewed the documentation and the GDR date reported should have been 7/6/18. It had been mismarked on the 2/21/19 quarterly and should have been coded on the 4/25/19 quarterly assessments. On 7/25/19 at 10:09 AM an interview with the Administrator was conducted. He stated it was his expectation for the MDS assessments to be correct. 3. Resident #150 had been admitted on 6/29/18. His diagnoses included COPD, muscle weakness, bilateral knee contractures, psychotic disorder, schizophrenia and major depressive disorder. Resident #150's ADL care plan indicated he required staff participation with dressing and personal hygiene and required assistance to use the toilet. Resident #150's Quarterly MDS assessment dated 2/5/19 indicated he had moderate cognitive impairment and required extensive assistance	F 641	Improvement committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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F 641	Continued From page 16	F 641		

with dressing, toileting and hygiene.
Resident #150's Quarterly MDS assessment dated 4/17/19 indicated he had moderate cognitive impairment and required supervision assistance with dressing, toileting and hygiene.
On 7/21/19 at an interview with Resident #150 was conducted. He stated he was able to do many things on his own. Resident #150 was observed lying in bed, his urinal was within reach and he wore bilateral knee braces.
On 7/24/19 at 12:25 PM an interview with the MDS Nurse #1 was conducted. The nurse stated the quarterly assessment of 4/17/19 had been coded incorrectly. She further stated that seeing a change in the Resident's ADL abilities the MDS nurse should have checked with the staff and clarified if the documentation was correct. The nurse stated the 7/3/19 annual assessment had been coded correctly for ADLs.
On 7/24/19 at 3:27 PM an interview with the 400-hall unit manager was conducted. She stated Resident #150's abilities could vary day to day. She stated he required extensive to total assistance for most ADLs including toileting. She stated his cognition also varied depending upon the time of the day.
On 7/25/19 at 8:02 AM an interview with Nurse Aide #1 (NA)who regularly cared for Resident #150 was conducted. The NA stated Resident #150 was alert and able to make his needs known. He could use his urinal and was also incontinent at times, and usually incontinent of bowel. She further stated he required extensive to total assistance with most ADLs including dressing, hygiene and toileting.
On 7/25/19 at 10:09 AM an interview with the Administrator was conducted. He stated it was his expectation for the MDS assessments to be correct.

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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 by: Based on observations and staff interviews, the facility failed to secure 3 of 8 medication carts observed (4th floor short hall, 3rd floor long hall, 4th floor long hall medication carts), and failed to discard expired medication from 1 of 4 medication carts reviewed (4th floor short hall medication cart). Findings included: 1. On 7/21/19 at 4:05 PM an observation was	F 761	" Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice 1. Latanoprost Ophthalmic solution located on fourth floor short hall med cart not dated and/or expired was immediately discarded.	8/22/19

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F 761	Continued From page 18 made of a medication cart parked against the wall across from the 4th floor nurses' station. The red dot on the side of lock was visible, indicating it was disengaged. A few moments later Nurse #5 arrived at the medication cart. On 7/21/19 at 4:07 PM an interview with Nurse #5 was conducted. The nurse stated this was the 4th floor short hall medication cart. She stated she had to quickly check on something and had not locked the cart. Nurse #5 demonstrated the cart had been left unlocked by opening a drawer on the cart. The nurse stated she should not have left the cart unlocked and unattended. On 7/25/19 at 10:09 AM an interview with the Administrator was conducted. The Administrator stated he would expect the nurses to lock the medication carts when unattended. 2. On 7/22/19 at 4:13 PM an observation was made of a medication cart parked against the wall across from the 3rd floor nurses' station. The red dot on the side of lock was visible, indicating it was disengaged. A few moments later Nurse #4 arrived at the medication cart. On 7/22/19 at 4:15 PM an interview with Nurse #4 was conducted. The nurse stated this was the 3rd floor long hall medication cart. She stated she had to retrieve a cup of applesauce from the kitchenette. She stated she had only been away for a few seconds. The nurse stated she should not have left the cart unlocked and unattended. On 7/25/19 at 10:09 AM an interview with the Administrator was conducted. The Administrator stated he would expect the nurses to lock the medication carts when unattended. 3. On 7/23/19 at 11:08 AM an observation was made of a medication cart parked against the wall outside of room 404. Medication Aide (MA) #1	F 761	" Address how the facility will identify other residents having the potential to be affected by the same deficient practice; 1. An audit will be completed by the Unit Coordinators /SDC/Supervisors and the Director of Nursing to identify any expired open medication by 08/22/2019. All expired medication will be discarded and re-ordered. 2. Current licensed staff and Medication aides will be re-educated starting on 08/13/2019 by the director of Nursing on storing and dating medications. 3. Current Licensed staff and Medication aides will be re-educated on 08/13/2019 by the Director of Nursing on securing medication carts. 4. This education will be added to the new hire process for new licensed nurses and medication aides. " Measures/Systematic changes put in place to ensure that the deficient practice does not reoccur: 1. The director of Nursing/Unit Coordinators or supervisors and SDC will monitor medication carts daily to ensure they are always secure 2. The Director of Nursing/SDC/Unit Coordinator and Supervisors will monitor medication carts via direct observation	

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F 761	Continued From page 19 had been observed standing at the cart. The MA then left the cart and walked into room 412, which was across and up the hall from room 404. The red dot on the side of lock was visible, indicating it was disengaged. A few moments later the MA returned to the medication cart. On 7/23/19 at 11:09 AM an interview with MA #1 was conducted. The MA demonstrated the cart had been left unlocked by opening a drawer. The MA stated this was the 4th floor long hall cart and when he left the cart unattended he should have locked it. The MA stated he had stepped into a room to hand something to a resident. On 7/25/19 at 10:09 AM an interview with the Administrator was conducted. The Administrator stated he would expect the MA to lock the medication carts when unattended. 4. On 7/24/19 at 3:43 PM an inspection of the 4th floor short hall medication cart was conducted with Nurse #6. One latanoprost ophthalmic solution (eye drops used to treat glaucoma), noted as opened on 6/4/19. Latanoprost manufacturer recommendations indicate that once a bottle is opened for use, it may be stored at room temperature for 6 weeks and then discarded. On 7/24/19 at 3:45 PM an interview with Nurse #6 was conducted. The Nurse stated the latanoprost eye drops should have been discarded six weeks after it had been opened, which would have been sometime last week. On 7/25/19 at 10:09 AM an interview with the Administrator was conducted. The Administrator stated he would expect the nurses to remove expired medications from the cart.	F 761	three times weekly to ensure medications re not expired. The results will be reported to the monthly to the Quality Assurance Committee for review and discussion. The Pharmacist will review medication storage monthly for 3 months to ensure medications are properly stored. This review will be presented to QAPI committee by the DON. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. " Indicate how the facility plans to monitor its performance to make sure that solutions are sustained 1.The Director of Nursing will present the results of the audits and inspections to the Quality Assurance performance improvement committee (QAPI) monthly for 3 months for any recommendations or modification.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		8/22/19

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F 812	Continued From page 20 §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, staff interviews and record review, the facility failed to label and date properly food stored in walk-in refrigerator in the kitchen and walk-in freezer, outside of the kitchen room. Findings included: 1. On 7/21/19 at 1:35 PM, an observation in the kitchen of foods, stored in the walk-in refrigerator, revealed two plastic bags of pancakes, one plastic bag of sausages and one plastic bag of hot dog sausages with no labels or dates on them. 2. On 7/21/19 at 1:45 PM, an observation of foods, stored in the walk-in freezer outside of	F 812	F 812 Food Procurement store/Preparation/serve sanitary " The plan of correcting the specific deficiency On July 21,2019, the two plastic bags of pancakes, one plastic bag of sausages and one plastic bag of hot dogs that were not labeled and dated in the walk-in refrigerator in dietary were discarded by the dietary manager. On July 21, 2019 the one plastic bag of chicken breasts that were not labeled and dated in the walk-in freezer in dietary was discarded by the dietary manager. " Address how the facility will identify other residents having the potential to be	

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F 812	Continued From page 21 kitchen, revealed one plastic bag of chicken breasts, with no label or date on it. On 7/21/19 at 2:00 PM, during an interview, the Dietary Manager indicated that all food packages should be properly labeled and dated. He mentioned that the policy/procedure for food delivery, inspection, distribution, labeling and appropriate storage was available and reviewed with all kitchen staff. On 7/21/19 at 2:10 PM, during an interview, the Assistant Cook indicated that all the kitchen staff was responsible for labeling food in the walk-in freezer and refrigerator, checking the expiration date and discarding the expired food. On 7/22/19 at 1:10 PM, during an interview, the Administrator indicated it was his expectation that staff labeled and dated food appropriately.	F 812	affected by the same deficient practice; No other items were noted in the walk-in refrigerator or freezer to not be labeled or dated " The monitoring processes and systemic changes to ensure plan of correction is effective: On 07/22/2019 the dietary manager re-educated current dietary staff that it is their responsibility to label and date food prior to placing in the walk-in refrigerator or walk in freezer. After 07/22/2019, no dietary staff will be allowed to work until the re-education is complete. This education will be part of the orientation process for all newly hired dietary employees. Beginning on 07/22/2019 a daily monitoring tool was put into place to monitor the dating and labeling of food by the dietary manger or cook. " Indicate how the facility plans to monitor its performance to make sure that solutions are sustained The daily rounds sheets will be reviewed by the administrator, regional dietary manager, and/or regional nurse consultant 2 times a week for 12 weeks to ensure all areas remain in compliance. The results of this review will be reported to the Quality assurance Performance improvement committee for any additional monitoring or modifications for three	

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F 812	Continued From page 22	F 812	months.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation	F 842		8/22/19

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F 842	Continued From page 23 purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, and record review the facility failed to document when dressing treatments to an advanced staged 4 pressure ulcer were performed or refused for 1 of 2 residents (Resident #391) reviewed with pressure ulcers. Findings included:	F 842	F 842 Resident Records " Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice	

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F 842	Continued From page 24 Record review revealed Resident #391 was admitted to the facility on 5/28/15 with cumulative diagnoses which included complete paraplegia . Review of the Weekly Pressure Wound Observation Tool dated 6/27/19 revealed on 8/12/16 Resident #391 acquired a sacrum pressure ulcer that progressed to a chronic stage 4 with tunneling. A stage 4 pressure ulcer is very deep, reaching into muscle and bone, causing extensive damage. Review of the physician orders beginning June 1, 2019 for the sacrum pressure ulcer included in part to flush the tunnels and cleanse the wound bed with normal saline. Pack base of 2 tunnels with Dakin 0.25% soaked Kerlix gauze. The Kerlix gauze to be a moist to a dry state. Cover with 1 (one) foam ABD pad and Sure site dressing twice a day. The second change was scheduled at bedtime (9 PM) for 2nd shift nurse to perform. Review of the Treatment Administration Record (TAR) revealed blank spaces with no initials to indicate whether the treatment had been performed or refused on 6/3/19-6/6/19, 6/8/19-6/10/19, 6/14/1915/19, 6/19/19, 6/21/19, 6/24/19, 6/26/19,6/28/19 and 6/29/19. Interview on 7/23/19 at 2:05 PM with Nurse #13 stated Resident #391 would not let male nurses perform his treatment. Interview on 07/23/19 at 3:04 PM with Nurse #8 stated she performed the treatment to the sacrum in the evening around 7 PM on 6/9/19 but forgot to initial that the treatment had been done.	F 842	Resident # 391 has been discharged " Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Current residents with pressure areas were audited for missing documentation for pressure ulcer care or refusal. Each Licensed nurse that failed to document was re-educated upon completion of the audit on 08/13/2019. " The monitoring processes and systemic changes to ensure plan of correction is effective: Licensed nurses were re-educated on 08/13/2019 on the professional expectations that when a treatment for pressure areas are completed, per physician□s orders it must be documented in Medical Record. Point Click Care Dash Board will be audited as well as treatment records 5 days a week for 12 weeks.by Director of Nursing Services/ Wound Nurse/ Unit managers to assure pressure wound treatments have been documented. " Indicate how the facility plans to monitor its performance to make sure that solutions are sustained	

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F 842	Continued From page 25 Interview on 7/24/19 at 11:56 AM with Nurse #9 who worked on 6/6/19 indicated she did not perform the treatment to the resident's pressure ulcer, but Nurse #10 may have performed the treatment. Interview via the phone on 7/25/19 at 9:59 AM with Nurse #11 stated if Resident #391 was in the building and not on his frequent leave of absence on 6/29/19, she did the treatment. Continued interview with Nurse #11 stated she does not know for sure if she the treatment change was done. Unsuccessful attempt to contact Nurse #10 via phone on 07/25/19 at 10:20 AM. An email was sent from the Administrator on 7/29/19 at 1:01 PM with attachments of employees' statements dated 7/25/19 who were assigned to perform treatments to Resident #391 sacrum pressure ulcer. Review of these statements revealed in part: " Nurse #12 (assigned to perform the treatment on 6/5/19,6/15/19, and 6/19/19, Resident #391" he did not let me do his treatment. "The statement further indicated the resident instructed Nurse #12 to get out of his room. " Nurse #14 was assigned to perform the treatment on 6/3/19 but the statement did not indicate whether the treatment had been performed or refused. " Nurse #2 was assigned to perform the treatment on 6/21/19. The statement indicated the treatment was not performed because the resident was on LOA and "I forgot to document on TAR he was out of facility."	F 842	Audits will be taken to QAPI meeting x 3 months by the Director of Nursing for discussion and review by the interdisciplinary team which consist of the Administrator, Director of Nursing, all department heads and the Medical Director, to assure continued compliance is maintained. Any concerns identified in the QAPI meeting will be discussed and an appropriate plan and interventions will be put into place. Upon completion of the initial 3 month process the QAPI team will discuss and determine if there is a need for continued monitoring. The Director of Nursing or nurse supervisor will audit systemic changes and be responsible for presenting information to the QAPI team.	

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F 842	Continued From page 26 " Nurse #5 was assigned on 6/8/19. The statement read" I did forget to document..." " Nurse #10 (worked for a nurse agency) was unable to contact him. Interview on 7/25/19 at 1:14 PM with the DON stated staff are expected to document whether treatments are performed or if refused.	F 842		
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 in observations and staff interviews, the facility's Quality Assurance and Performance Improvement (QAPI) Committee failed to maintain implemented procedures and monitor interventions previously put in place following the recertification survey of 8/23/18. This was for two deficiencies that were originally cited in August 2018 and subsequently recited on the current recertification survey of 7/25/19. The repeated deficiencies are in the area of CFR 483.10, Safe/Clean/Comfortable/Homelike Environment, and CFR 483.45, Label/Storage of Drugs and Biologicals. The facility's continued failure during the recertification survey showed a pattern of the facility's inability to sustain an effective QAPI program. Findings included: 1. F584: Based on resident interviews, staff interviews and observations the facility failed to	F 867	F 867 " Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice 1. On 07/25/2019 the Medical Director was notified of Department of Health Services Regulatory exit with recommendation of repeat tags for failure to properly store drugs, F Tag 761 and for failure to properly store food, F tag 812 by the Administrator. " Address how the facility will identify other residents having the potential to be affected by the same deficient practice; 1. On 08/20/2019 the facility QAPI	8/22/19

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F 867	Continued From page 27 (1) maintain floor tiles in the resident room, resident bathrooms, dining room and hallways, (2) maintain walls in good repair, (3) maintain a bedside table and cabinet in good repair, (4) maintain a clean elevator floor and elevator tracks that are clean and in good repair, (5) maintain clean equipment in resident rooms, (6) maintain clean and paint chipped free handrails, (7) maintain clean windows in the dining room. This was evident in 1 of 4 resident care units (Unit 200). This tag is cross referenced to: During the recertification survey of 8/23/18 the facility was cited for failing to (1) maintain walls and ceilings in resident rooms for 13 of 16 rooms (rooms 200, 206, 218, 229, 306, 315, 403, 414, 420, 427, 429, 431 and 530), (2) maintain a clean environment in resident rooms for 4 of 16 rooms (rooms 229, 414, 420 and 427), (3) provide nightstands without missing drawers in resident rooms for 2 of 16 rooms (rooms 427 and 530), and (4) provide sufficient and clean linens that were not stained, thread bare or torn on 2 of 4 resident care units (units 300 and 500). An interview was conducted on 7/25/19 at 1:44 PM with the Regional Managers who monitor facility performance. Regional Manager #1 stated there was a change of ownership 5/1/19. She stated a new environmental company had been hired in June 2019 and some details were still being worked out. She stated when the change of ownership had occurred, some of the QAPI projects in progress had not been kept up. She also stated she could understand how this citation had been repeated but believed conditions had improved.	F 867	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. 2 On 08/20/2019 the administrator re-educated 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 storage of medication, disposing of expired medications, and labeling and dating food in the coolers 3 An audit will be completed by the unit coordinators and the Director of Nursing to identify any expired open medication by 07/26/2019. All expired medication will be discarded and re-ordered. " The monitoring processes and systemic changes to ensure plan of correction is effective: 1. On 07/26/2019 the Administrator was re-educated on the Quality Assurance and Improvement Plan policy by the regional nurse Consultant. Resources for further education, and ongoing support provided. 2. The Facility QAPI Committee will	

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F 867	Continued From page 28 2. F761: Based on observations and staff interviews, the facility failed to secure 3 of 8 medication carts observed (4th floor short hall, 3rd floor long hall, 4th floor long hall medication carts), and failed to discard expired medication from 1 of 4 medication carts reviewed (4th floor short hall medication cart). This tag is cross referenced to: During the recertification survey on 8/23/18 the facility was cited for failing to secure a prescription bottle of nystatin powder for 1 resident. An interview was conducted on 7/25/19 at 1:44 PM with the Regional Managers who monitor facility performance. Regional Manager #1 stated there was a change of ownership 5/1/19. She stated when the change of ownership had occurred, some of the QAPI projects in progress had not been kept up. She also stated since the change of ownership, the facility had been working with a new pharmacy service and had received new medication carts. The nurses had been accustomed to medication carts that automatically lock, and the new carts do not automatically lock. She further stated the new pharmacy service was to come in on a monthly basis to do audits and check for expired medications.	F 867	meet at a minimum of monthly and QAPI committee meeting a minimum of quarterly to identify issues related to drug storage and food procurement. 3. The Director of Nursing/designee will monitor medication carts via direct observation three times weekly to ensure medications are not expired. The results will be reported to the monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. 4. Beginning on 07/22/2019 a daily monitoring tool was put into place to monitor the dating and labeling of food by the dietary manger or cook. " Indicate how the facility plans to monitor its performance to make sure that solutions are sustained 5. The QAPI committee will continue to meet at a minimum of Quarterly. 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 facilities progress in correction of deficient practices or identify concerns.	

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F 867	Continued From page 29	F 867	The administrator will be responsible for ensuring committee concerns are addressed through further training or other interventions	
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain one of one walk-in refrigerator in safe operating condition. Findings included: On 7/21/19 at 1:45 PM, the observation of the walk-in refrigerator in the kitchen revealed the door lock was broken, which kept the door in one inch opened position. The outside thermometer, mounted on the wall, indicated 47*F. Inside the walk-in refrigerator, there were two thermometers, located in opposite ends of the refrigerator, indicated 57*F and 47*F. On 7/21/19 at 1:45 PM, during an interview, the Dietary Manager indicated that the issue with walk-in refrigerator door was reported several weeks ago, the maintenance staff repaired it, but the door lock could not hold the door in closed position. The administration and maintenance were aware of it. The Dietary Manager mentioned he was waiting for maintenance to fix the problem. On 7/21/19 at 1:55 PM, during an interview, the	F 908	F 908 Essential Equipment, safe operating Condition " Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice 1. On 07/22/2019 the latch on the walk in refrigerator was replaced and is closely properly to hold the proper temperature " Address how the facility will identify other residents having the potential to be affected by the same deficient practice; 1. All other refrigeration units close and latch properly " The monitoring processes and systemic changes to ensure plan of correction is effective: 1. On 07/22/2019 the dietary staff were re-educated by the administrator to notify the administrator if equipment is not	8/22/19

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F 908	Continued From page 30 assistant cook indicated that he observed the walk-in refrigerator door in not closed/locked position, and was sure that the Dietary Manager reported it to the maintenance staff. On 7/22/19 at 10:55 AM, during an interview, the Maintenance Director indicated that he worked with the issue of walk-in refrigerator door in the kitchen about week ago. He fixed the latch of the door and left it in good working condition. Since that time, nobody reported any issue with the same door to him. He planned to check the door lock condition today and order new parts. On 7/22/19 at 12:55 PM, during an interview, the Administrator indicated he expected the kitchen staff to maintain the equipment in good shape and safe operating conditions.	F 908	working properly in the kitchen in addition to completing the request for the maintenance department. 2. The dietary manager or cook will document daily on a log the condition of the latch and if it is working and the cooler temperature daily for 12 weeks to ensure the temperature of the food is safe. " Indicate how the facility plans to monitor its performance to make sure that solutions are sustained 1. The daily log results will be reviewed by the administrator, regional dietary manager, and/or regional nurse consultant 2 times a week for 12 weeks to ensure all areas remain in compliance. The results of this review will be reported to the Quality assurance Performance improvement committee for any additional monitoring or modifications for three months.	