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F 254 SS=D	483.15(h)(3) CLEAN BED/BATH LINENS IN GOOD CONDITION The facility must provide clean bed and bath linens that are in good condition. This REQUIREMENT is not met as evidenced by: Based on observations, family interviews, and staff interviews the facility failed to provide bed linens in good and clean condition for 1 of 1 residents reviewed for cleanliness and condition of bed linens (Resident #117). The findings included: Review of the medical record revealed Resident #117 was re-admitted to the facility on 03/13/15 and the most recent Quarterly Minimum Data Set (MDS) dated 05/15/15 revealed Resident #117 was severely impaired for cognitive skills for daily decision making. Review of the facility record shower list revealed Resident #117 was scheduled to receive showers on Tuesdays and Fridays. During an observation on 05/18/15 at 3:39 PM Resident #117's bed linens was observed to be torn in somewhat of a V-shape at the head of the bed (top) and to the left side of the torn area on the fitted bed sheet were two brown colored stains, circle shaped, approximately 2 inches long by 2 inches wide, and with further observation of food crumbs in the resident's bed. During an observation on 05/19/15 at 8:34 AM Resident #117's fitted bed sheet remained with the same V-shaped torn area and with the two	F 254	F- 254 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. Interventions for affected resident: Bed Linens for Resident #117 were changed Interventions for residents identified as having the potential to be affected: A facility audit was performed by the Director of Nursing (DON) and Unit Manager (UM) to ensure no other resident had soiled bed linens on their bed. If bed linens were found to be soiled, the bed linens were immediately changed by facility staff. A linen audit was performed	6/19/15

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

Electronically Signed | 06/12/2015

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F 254	Continued From page 1 brown colored stains to the left at the top of the bed. During an observation on 05/19/15 at 10:53 AM Resident #117's fitted bed sheet remained with the same V-shaped torn area, and the same two brown colored stains to the left at the top, and with further observation bread crumbs were observed in the resident's bed. During an interview on 05/19/15 at 12:49 PM Resident #117's family member stated that she had observed the same fitted bed sheet on the resident's bed for 2 weeks. The family member indicated she knew it was the same bed sheet because of the torn area at the top (head of the bed) and the two brown colored stains. The family member revealed she had first noticed the torn area and the stains on Thursday 05/07/15 and she had further observed the same torn area and brown colored stains on Wednesday 05/13/15. The family member further stated when she and another family member had visited Resident #117 on Saturday 05/16/15 the fitted bed sheet was observed again on the resident's bed with the same torn area and with the same brown colored stains. During the interview on 05/19/15 at 12:53 PM Resident #117's family member was observed to pull the bed covers down and half way down in the bed on the middle portion of the fitted bed sheet was a 2 inch long by 2 inch wide brown colored stain. During an interview on 05/21/15 at 5:56 PM Nurse Aide (NA) #2 stated she was responsible for the showers of residents 5 days a week and that Resident #117 received showers on	F 254	by the Housekeeping Supervisor to ensure no other linen was found to have tears, holes and/or stains. If tears, holes and/or stains were noted in any linen, the linen was immediately discarded. Licensed Nurses (LN) and Certified Nursing Assistants (CNA) were educated by the Staff Development Coordinator on ensuring bed linens are changed twice weekly as per shower schedule and as needed if bed linens are noted to be soiled. Housekeeping Supervisor educated Housekeeping staff on ensuring an inspection of the linen is completed prior to placing linens on clean linen carts to ensure no tears, holes and/or stains are noted in the linen. Systematic Change: Director of Nursing (DON) or Staff Development Coordinator (SDC) will audit ten (10) resident bed linens weekly for three (3) months to ensure bed linens are free from soil and/or tears. Housekeeping Supervisor will inspect two (2) clean linen carts weekly for three (3) months to ensure linen is free from tears, holes and/or stains. Newly hired Licensed Nurses and Certified Nursing Assistants will be educated on ensuring bed linens are changed twice weekly as per shower schedule and as needed if bed linens are noted to be soiled. Newly hired Housekeeping staff will be educated on ensuring an inspection of linen is	

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F 254	Continued From page 2 Tuesdays and Fridays. NA #2 stated she was unsure but thought Resident #117 had a shower on Tuesday 05/19/15. NA #2 further stated the NAs assigned to the residents on the halls were responsible for changing the bed linens on the resident's shower days and as needed when linens were dirty or soiled. During an interview on 05/22/15 at 9:06 AM Nurse #1 stated Resident #117's bed linens should have been changed on the resident's shower day and any time they were soiled. The nurse further stated it was her expectation that sheets were changed on shower days Tuesday and Friday for Resident #117 or anytime they were soiled. During an interview on 05/22/15 at 9:58 AM NA #3 stated she was unaware of Resident #117's last shower or when the bed linens were changed. NA #3 explained that showers included, hair washing, nail care, clean clothes, and clean bed linens. She stated she had not changed Resident #117's bed linens or assisted her with a shower on Tuesday or Friday. She further stated she was unable to recall if Resident #117 had ever refused a shower on Tuesdays or Fridays. During an interview on 05/22/15 at 11:32 AM the Unit Manager (UM) stated she would have expected the bed linens to have been changed on Resident #117's shower days and/or changed when visibly soiled and should the bed linens looked to be soiled or dirty she would have expected them to have been changed. During an interview on 05/22/15 at 5:32 PM the Director of Nursing (DON) stated it was her expectation the bed linens should be changed	F 254	complete prior to placing linens on clean linen carts to ensure no tears and/or holes are noted in the linen. Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three months, the DON and Housekeeping Supervisor will report results of the bed linen audits completed to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	

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F 254	Continued From page 3 twice a week on the resident's shower days Tuesdays and Fridays and more often when the linens were soiled. During an interview on 05/22/15 at 6:31 PM the Administrator stated it was his expectation that soiled linens be changed on the resident's shower days and more frequently should the linens be soiled.	F 254		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential;	F 272		6/19/15

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F 272	Continued From page 4 Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to include a clear description of the problems, causes, contributing factors and risk factors of the problem and analyze how these affected the residents' functionality in the care area assessments for 8 of 24 sampled residents (Residents #29, #33, #60, #93, #132, #63, #9, #170). The findings included: 1. Resident #132 was admitted on 10/25/13. His diagnoses included cerebral vascular accident with hemiplegia, dysphagia, chronic pain syndrome, depressive disorder and chronic airway obstruction. The annual Minimum Data Set (MDS) dated 09/08/14 coded him with intact cognition and having verbal behaviors 1-3 days. The MDS triggered the areas of Cognitive Loss/Dementia, Psychosocial Well-being and Behavioral Symptoms as needing to be assessed. The Care Area Assessment (CAA), written by the Social Worker (SW), failed to comprehensively assess and analyze the problem and how the problem affected Resident #132's functionality as follows:	F 272	F-272 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance as outlined. To remain in compliance with all federal and state regulations the center has correction constitutes the center's allegation of compliance. All alleged deficiency cited have been or will be completed by the date indicated. Interventions for affected residents The following resident's Psychosocial Care Area Assessment (CAA) was updated by the Social Worker to reflect a comprehensive assessment analyzing psychosocial problems and how the problem affects the resident's psychosocial function.	

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F 272	Continued From page 5 a. Cognitive Loss/Dementia dated 09/08/14 stated the "Resident is alert and very well oriented and knows what he is doing. He will get upset about something every now and then and exhibit inappropriateness. Family members are aware of these inappropriate behaviors and tries to work with him on them." b. Psychosocial Well-Being dated 09/08/14 stated "Resident is a young male that acts out possibly due to having to be in a facility when he is a young man. He is alert and oriented and can make any needs and wants known well he goes outside for cigarettes and does well. He gets frustrated I feel because he is a young man in this environment. Family very supportive and aware of his behaviors family very supportive of staff as well." c. Behavioral Symptoms dated 09/08/14 stated "Resident exhibits inappropriate behavior at times by being abusive verbally to staff members. Resident's family supportive and attentive visits daily and makes sure he has what he needs and even what he may want. They are aware of his behaviors." During interview with SW on 05/22/15 at 4:41 PM, she revealed that since last May she lost her assistant who had the responsibility of completing the MDS and CAAs. Since the assistant left she had to add this to her other job duties. She further stated she had received no training other than the pointers the MDS nurses provided her. She stated she did not know she needed to be more individualized and detailed on the CAAs. 2. Resident #93 was admitted to the facility on 02/10/12 with diagnoses of Diabetes, chronic airway obstruction, insomnia, obstructive sleep apnea, depressive disorder and atrial fibrillation. The annual MDS dated 11/11/14 coded her with	F 272	Residents #132 CAA dated 9/8/14 Resident #93 CAA dated 11/11/14 Resident #29 CAA dated 3/17/15 Resident #33 CAA dated 4/1/15 Resident #60 CAA dated 7/21/14 Resident #63 CAA dated 1/30/15 Resident #9 CAA dated 3/13/15 Resident #170 CAA dated 4/29/15 Interventions for residents identified as having the potential to be affected. Minimum Data Set (MDS) Consultant and MDS Nurse(s) re-educated the Social Worker on thoroughly assessing and individualizing psychosocial Care Area Assessments (CAA). Re-education included the need to provide a clear description of the resident's psychosocial problem, risk factors of the psychosocial problem and analysis of how these problems affect the resident's functionality. Any newly hired Social Worker will be educated on comprehensively and thoroughly assessing and completing psychosocial CAA's. Systematic Change: MDS Nurse(s) or MDS Consultant will audit eight (8) residents' psychosocial CAA's weekly for twelve (12) weeks. This audit will include ensuring the psychosocial CAA provides a clear description of the resident's psychosocial problems and analysis of how these	

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F 272	Continued From page 6 intact cognitive skills, having rejection of care 1 - 3 days, and requiring extensive assistance with most activities of daily living skills. The MDS triggered the areas of Cognitive Loss/Dementia and Behavioral Symptoms as needing to be assessed. The Care Area Assessment (CAA), written by the Social Worker (SW), failed to comprehensively assess and analyze the problem and how the problem affected Resident #93's functionality as follows: a. Cognitive Loss/Dementia dated 11/11/14 stated "Resident is very alert and oriented verbally responsive and attends activities. She refused Lasix (a diuretic) on 11/4/14 stated that it was too much. Family is totally supportive and attentive visits very often." b. Behavioral Symptoms dated 11/11/14 stated "Resident rejected care by refusing Lasix on 11/4/14. Resident is very alert and oriented and in a big participant in activities. Family totally supportive and attentive visits very often." During interview with SW on 05/22/15 at 4:41 PM, she revealed that since last May she lost her assistant who had the responsibility of completing the MDS and CAA's. Since the assistant left she had to add this to her other job duties. She further stated she had received no training other than the pointers the MDS nurses provided her. She stated she did not know she needed to be more individualized and detailed on the CAAs. 3. Resident #29 was admitted to the facility on 02/06/13 with diagnoses including chronic airway obstruction, congestive heart failure, Diabetes, and anxiety. The annual MDS dated 03/17/15 coded her with having intact cognitive skills, rejection The MDS triggered the areas of Cognitive Loss/Dementia	F 272	problems affect the resident's functionality. Monitoring of the change to sustain system compliance ongoing. Monthly for a minimum of three months, the Director of Nursing or MDS Nurse(s) will report results of the audits to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	

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and Behavioral Symptoms as needing to be assessed.
The Care Area Assessment (CAA), written by the Social Worker (SW), failed to comprehensively assess and analyze the problem and how the problem affected Resident #29 functionality as follows:
a. Cognitive Loss/Dementia dated 03/18/15 stated "Resident is alert and very oriented she is verbally responsive and makes needs known well as well as her wants. She did refused (sic) treatment. Family very supportive and attentive visits regularly."
b. Behavioral Symptoms dated 03/18/15 stated "Resident is very alert and oriented and readily makes her needs and wants known well. She is very outspoken and will let you know how she feels about something. She can be demanding at times. Family very supportive and attentive."
During interview with SW on 05/22/15 at 4:41 PM, she revealed that since last May she lost her assistant who had the responsibility of completing the MDS and CAAs. Since the assistant left she had to add this to her other job duties. She further stated she had received no training other than the pointers the MDS nurses provided her. She stated she did not know she needed to be more individualized and detailed on the CAAs.

4. Resident #33 was admitted to the facility on 03/23/15 with diagnoses including congestive heart failure, unsteady gait, difficulty breathing, Diabetes, senile degenerative of brain, depression and anxiety.
The admission MDS dated 04/01/15 coded her with long and short term memory impairments, having no behaviors, and requiring extensive assistance with all activities of daily living skills. The MDS triggered the areas of cognition,

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psychosocial and behaviors as needing to be assessed.
The Care Area Assessment (CAA), written by the Social Worker (SW), failed to comprehensively assess and analyze the problem and how the problem affected Resident #33's functionality as follows:
a. Cognitive Loss dated 04/03/15 stated "Resident is alert but has cognitive issues. Memory problems She said today is Tuesday when it is rally Friday. She said the month is December when it is actually April. Family supportive and attentive."
b. Psychosocial Well-Being dated 04/03/15 stated "Resident is alert but has memory problems cognition is not good. Family supportive and attentive visits regularly."
During interview with SW on 05/22/15 at 4:41 PM, she revealed that since last May she lost her assistant who had the responsibility of completing the MDS and CAAs. Since the assistant left she had to add this to her other job duties. She further stated she had received no training other than the pointers the MDS nurses provided her. She stated she did not know she needed to be more individualized and detailed on the CAAs.

5. Resident #60 was admitted to the facility on 03/28/13. Her diagnoses included dementia, hypertension, and depressive disorder.
The annual MDS dated 07/21/14 coded her with long and short term memory impairment and having severely impaired decision making skills. She was also coded as requiring extensive assistance for most activities of daily living skills. The MDS triggered the areas of cognition, psychosocial and behaviors as needing to be assessed.
The Care Area Assessment (CAA), written by the

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Social Worker (SW), failed to comprehensively assess and analyze the problem and how the problem affected Resident #60's functionality as follows:
a. Cognitive Loss/Dementia dated 07/22/14 stated "Resident is alert but has confusion and memory problems. Family very supportive and attentive visits very often and attentive to any needs or wants. They visit at least daily or every other day."
During interview with SW on 05/22/15 at 4:41 PM, she revealed that since last May she lost her assistant who had the responsibility of completing the MDS and CAAs. Since the assistant left she had to add this to her other job duties. She further stated she had received no training other than the pointers the MDS nurses provided her. She stated she did not know she needed to be more individualized and detailed on the CAAs.

#6. Resident #63 was re-admitted to the facility 01/23/15 with diagnoses which included paralysis, diabetes, thyroid disease, difficulty swallowing and infection of bone.

A review of a Minimum Data Set (MDS) for a significant change assessment dated 01/30/15 indicated Resident #63 had no short term or long term memory problems and had modified independence in daily decision making. The MDS triggered the areas of Cognitive Loss/Dementia and Behavioral Symptoms as needing to be assessed.

The Care Area Assessment (CAA) written by the Social Worker (SW) failed to comprehensively assess and analyze the problem and how the problem affected Resident #63's functionality as follows:

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a. Cognitive Loss/Dementia dated 01/30/15 indicated resident has some cognition issues and is modified independence requiring some supervision.

b. Behavioral Symptoms dated 01/30/15 indicated resident is alert and does need some supervision due to being modified independence. Resident has had a behavior by refusing to take a shower on 01/27/15.

During an interview with the SW on 05/22/15 at 4:41 PM, she revealed that since last May she lost her assistant who had the responsibility of completing the MDS and CAAs and since the assistant left she had to add this to her other job duties. She stated she had received no training other than the pointers the MDS nurses provided her. She further stated she did not know she needed to be more individualized and detailed on the CAAs.

#7. Resident #9 was admitted to the facility on 03/06/15 with diagnoses which included generalized muscle weakness; difficulty in walking; type 2 diabetes, depression and dementia.

A review of the admission Minimum Data Set (MDS) dated 03/13/15 indicated Resident #9 had short term and long term memory problems and was moderately impaired in cognition for daily decision making. The MDS triggered the area of Cognitive Loss/Dementia as needing to be assessed.

The Care Area Assessment (CAA) written by the Social Worker (SW) failed to comprehensively assess and analyze the problem and how the problem affected Resident #9's functionality as

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follows:

a. Cognitive Loss/Dementia dated 01/30/15 indicated resident is alert but has cognitive issues related to mild to moderate dementia. She is verbally responsive. She did realize that today March 13 is her birthday. She is pleasantly confused.

During an interview with the SW on 05/22/15 at 4:41 PM, she revealed that since last May she lost her assistant who had the responsibility of completing the MDS and CAAs and since the assistant left she had to add this to her other job duties. She stated she had received no training other than the pointers the MDS nurses provided her. She further stated she did not know she needed to be more individualized and detailed on the CAAs.

8) Resident #170 was admitted to the facility on 04/22/15. Diagnoses included dementia with behavioral disturbances and metabolic encephalopathy.

Review of the admission Minimum Data Set (MDS) dated 04/29/15 revealed the resident had short-term and long-term memory problems and had severely impaired daily decision-making skills.

Review of the Care Area Assessment (CAA) section of the MDS revealed Cognitive Loss/Dementia had triggered for further assessment and consideration for care planning.

The analysis of findings section stated Resident #170 had cognitive issues and acted out inappropriately related to a medical diagnosis of dementia. The CAA did not contain any causative or contributive factors, resident or family input, or risk factors related to the resident's cognitive loss or dementia.

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F 272	Continued From page 12 An interview was conducted with the Social Worker on 05/22/15 at 4:49 PM. She stated the CAA should have been an overview of the resident's triggered care area. The Social Worker stated she knew she was not completing the CAA in the way it should have been completed, but she explained she had never received any formal training on how to complete a CAA correctly.	F 272		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a	F 278		6/19/15

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F 278	Continued From page 13 material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to accurately complete the Minimum Data Sets (MDSs) for 2 of 24 sampled residents whose MDSs were reviewed for accuracy. Resident #132's MDS did not reflect his Pre-admission Screening and Resident Review (PASRR) Level ll and Resident #33's MDS did not reflect her respite stay in the facility. The findings included: 1. Resident #132 was admitted on 10/25/13. His diagnoses included cerebral vascular accident with hemiplegia, dysphagia, chronic pain syndrome, depressive disorder and chronic airway obstruction. A Pre-admission Screening and Resident Review (PASRR) Level ll letter was in his medical record showing he qualified for a time limited stay in the facility from 08/27/13 through 11/25/13. Review of the medical record revealed a letter completed 07/02/14 with a hand written signed note on the top that stated Resident #132 had a Pre-admission Screening and Resident Review (PASRR) Level ll. The annual MDS dated 09/08/14 coded him with intact cognition and having verbal behaviors 1-3 days. The MDS marked NO to the question "Has the resident been evaluated by Level II and determined to have a serious mental illness and/or mental retardation or a related condition?" Interview with the MDS nurse on 05/22/15 at 11:59 AM revealed she usually reviewed the chart, face sheet and FL-2 form to locate any information related to PASRR in order to mark the MDS correctly. She stated she missed the letter	F 278	F- 278 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. Interventions for affected resident: Resident # 132 - Minimum Data Set (MDS) assessment dated 09/08/14 was corrected by the facility MDS Nurse to reflect Resident #132 had a Level II Pre-admission Screening and Resident Review (PASSAR). Resident #33 - Minimum Data Set (MDS) assessment dated 04/01/15 was corrected by the facility MDS Nurse to accurately reflect Resident #33 received Respite care services within 14 days while in the facility. Interventions for residents identified as having the potential to be affected:	

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F 278	Continued From page 14 of 07/02/14 and the MDS should have reflected the Level ll PASRR. 2. Resident #33 was admitted to the facility on 03/23/15 with diagnoses including congestive heart failure, unsteady gait, difficulty breathing, Diabetes, senile degenerative of brain, depression and anxiety. A nursing note dated 03/23/15 at 11:46 AM stated that Resident #33 was admitted to the facility for a 5 stay respite care stay. An activity note dated 03/23/15 (no time) stated Resident #33 was admitted today for a 5 day respite stay. A social note dated 03/24/15 (no time) stated this resident was admitted on 03/23/15 from home for 5 days of respite care. The FL2 signed by the physician on 04/01/15 noted Resident #33 was changed from a respite level of care to a skilled nursing facility level of care. The admission MDS dated 04/01/15 coded her with long and short term memory impairments, having no behaviors, and requiring extensive assistance with all activities of daily living skills. This MDS failed to mark the section which indicated Resident #33 received respite care within the last 14 days while in the facility. Interview with the MDS nurse on 0/22/15 at 12:47 PM revealed Resident #33 was admitted under respite care, then changed to private pay and then became palliative care. MDS nurse stated she should have marked that the resident received respite care.	F 278	An audit was performed by the facility MDS Nurse(s) on current resident's most recent completed MDS assessment to ensure coding accuracy noting Level II PASSAR (if applicable) under Section (A) Identification/Information and ensuring coding accuracy noting Respite Care Services (if applicable) under Section (O)Special Treatments/Procedures/Programs. Any coding errors noted were corrected as applicable. Systematic Change: Director of Nursing (DON) has in-serviced the MDS Nurse(s) on accurately assessing residents and appropriately coding Level II PASSAR (if applicable) under Section (A) - Identification/ Information and accurately assessing and appropriately coding Respite Care Service (if applicable) under Section (O) - Special Treatments/Procedures/Programs. DON will complete a 10% sample audit of the MDS assessments completed each month to ensure Level II PASSAR and Respite Care Services are being accurately assessed and coded on the MDS assessment. Audits will be completed monthly for twelve (12) months. Newly hired MDS Nurse(s) will be in-serviced during the orientation period on importance of accurately assessing and coding MDS's. Monitoring of the change to sustain	

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F 278	Continued From page 15	F 278	system compliance ongoing: Monthly for a minimum of twelve (12) months, the DON will report the following audits to the Quality Assurance and Performance Improvement Committee: (a) Number of residents that did not have accurate MDS assessments noting: Respite Care Services Level II PASSAR (b) Number of newly hired MDS Nurse(s) that did not receive in-servicing during their orientation on accurately coding Level 2 PASSAR under Section (A) and accurately coding Respite Care Services under Section (O) of the MDS assessment. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the twelve (12) months.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in	F 280		6/19/15

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F 280	Continued From page 16 disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review, family interview, and staff interviews the facility failed to update the care plan to include meal assisted devices and a family's request for the residents hands to be washed before each meal for 1 of 3 residents reviewed for activities of daily living (Resident #117). The findings included: Resident #117 was re-admitted to the facility on 03/13/15 with diagnosis which included cerebral vascular accident (stroke), aphasia (loss of ability to understand or express speech), muscle weakness, and high blood pressure. Review of an Occupational Therapists (OT) recommendation dated 03/13/15 indicated Resident #117 had no problems with swallowing/chewing/eating with a plate guard around half of the plate and weighted (built-up) utensils for each of her meals. The most recent quarterly Minimum Data Set (MDS) dated 05/15/15 revealed Resident #117 had severe cognitive impairment for daily decision making. Resident #117 required	F 280	F- 280 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. Interventions for affected resident: Resident # 117 care plan was updated by the Minimum Data Set (MDS) Nurse(s) to reflect a plate guard should be utilized around half of the plate and weighted (built-up) utensils used with every meal. Resident #117 care plan was updated by the MDS Nurse(s) to include cleansing hands before meals.	

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F 280	Continued From page 17 extensive assistance with 2 person physical assist for bed mobility and transfers, extensive assistance with 1 person physical assist for dressing, eating, and personal hygiene, and was totally dependent on staff for toileting and bathing. Review of a care plan dated 05/15/15 revealed the resident was at risk for nutrition/dehydration due to requiring assistance with activities of daily living (ADLs). The care plan indicated Resident #117 would consume 75% of her meals and fluids with interventions to assist with meals as ordered, offer fluids during care, and provide food preferences and substitutions. The care plan did not indicate that Resident #117 required a plate guard around half of the plate and weighted (built-up) utensils with every meal. Further review of the care plan dated 05/15/15 revealed self-care deficit due to cognition, history of stroke, and aphasia. The care plan indicated Resident #117's ADLs would be met with interventions of staff assistance with ADLs, bed bath for bathing except on shower days, and privacy during care. Further review of the care plan did not indicate that Resident #117 should have her hands washed before each meal per the family's request. Continued review of the care plan dated 05/15/15 revealed the care plan was reviewed by the facility staff on 03/23/15 and 05/15/15 with no indication that the care plan had been updated for a plate guard, weighted utensils, and/or for the resident's hand/s to be washed before every meal. An interview was conducted with Resident #117's family member on 05/19/15 at 12:49 PM. The	F 280	Interventions for residents identified as having the potential to be affected: A review was completed by the facility MDS Nurse(s) on current resident's Activities of Daily Living (ADL) care plan to ensure accuracy. Any ADL care plan noted to have omissions or errors was corrected as applicable. Systematic Change: Director of Nursing educated MDS Nurse(s) on accurately updating comprehensive care plans. An audit will be completed monthly on 10% of the completed comprehensive care plans to ensure accuracy of care plan. This audit will be completed monthly for a minimum of three (3) months. Newly hired MDS Nurse(s) will be educated on the importance of accurately updating comprehensive care plans. Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three months, the DON will report the results of the comprehensive care plan audits to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	

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F 280	Continued From page 18	F 280		

family stated the plate guard and the weighted utensils were usually always on the resident's meal tray. The family further stated they had placed a sign on the wall above the resident's bed when she was admitted to the facility in hopes that it would be a reminder to the nursing staff to wash the resident's hands before every meal. The family was observed to wash Resident #117's hands after the Nurse Aide (NA) set up Resident #117's lunch meal tray. The family indicated there were numerous times when they had to wash Resident #117's hands because the nursing staff would come into the room, set up the resident's meal tray, and then leave. The family further indicated they had complained to the Director of Nursing (DON) related to the NAs being observed as to not wash Resident #117's hands before she would eat.

An interview was conducted with Nurse Aide (NA) #2 on 05/21/15 at 5:56 PM. She confirmed she had set up Resident #117's dinner meal tray, she had placed the plate guard around half of the resident's plate, and she ensured the weighted utensils were on the meal tray and available to be used by the resident. NA #2 indicated she was aware of the sign on the wall in the resident's room which indicated that the resident's hands were supposed to be washed before she would start to eat at every meal. NA #2 provided no explanation as to why she had not washed Resident #117's hands.

An interview was conducted with Nurse #1 on 05/22/15 at 9:06 AM. She stated it was her expectation for the NAs to ensure Resident #117's plate guard and weighted utensils were available on each of her meal trays. She further stated she expected the NAs to have always

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F 280	Continued From page 19 washed Resident #117's hands before she would start to eat. No explanation was given for the resident's hands not being washed and/or the resident's ADL needs not being transcribed onto the care plan. An interview was conducted with the Director of Nursing (DON) on 05/22/15 at 5:32 PM. She stated she expected the NAs and nurses to ensure Resident #117's plate guard and weighted utensils were available on all of her meal trays. She further stated she would have expected the NA to have washed Resident #117's hands before every meal. She indicated she would have expected the care plan to have been updated and to have reflected the needs of the resident.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to follow the care planned intervention for the use of a pull/tab alarm for 1 of 3 residents sampled for accidents (Resident #18). The findings included: Resident #18 was admitted to the facility on 12/29/14. His diagnoses included pneumonia, acute respiratory failure, difficulty walking, dysphagia, muscle weakness, Diabetes, dementia, and anxiety state.	F 282	F- 282 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of	6/19/15

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F 282	Continued From page 20 The admission Minimum Data Set (MDS) dated 01/05/15 coded him as having intact cognition, requiring extensive assistance for most activities of daily living skills (ADLs), only being able to steady himself with human assistance, being frequently incontinent and having no fall history. The Fall Care Area Assessment dated 01/09/15 noted he required extensive assistance with bed mobility and transfers, ambulated with a walker and one person assist, had no falls and was on therapy's caseload. The quarterly MDS dated 03/24/15 coded him with severely impaired cognition, requiring extensive assistance with most ADLs, being totally incontinent of bladder, frequently incontinent of bowel and having had no falls. Nursing notes dated 05/01/15 at 2:30 PM revealed Resident #18 fell when he attempted to rise from the toilet unassisted and slid down the wall. A nursing note dated 05/04/15 at 9:30 AM stated a pull tab alarm was initiated after this fall. The fall care plan was updated on 05/01/15 to reflect a pull/tab alarm was added as an intervention to meet the goal for Resident #18 to not sustain a fall with significant injury through the next review. In addition, the Interim Plan of Care, undated, which was used by nurse aides to refer to for individual care needs, included the "pull tab alarm on wheelchair." On 05/20/15 at 2:18 PM staff asked him if he wanted to get up for an activity and Resident #18 stated yes. Resident #18 was observed being transferred to a wheelchair by nurse Aide (NA) #1 and NA #5. He required extensive assistance to stand and shuffle small unsteady steps with each aide on either side of him. The pull tab alarm was located on the back of the wheelchair with the clip attached to the magnet of the alarm at this time. Resident #18 was observed sitting in his	F 282	correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. Interventions for affected resident: Resident #18 was reviewed by Interdisciplinary Team. Care plan was revised and tab alarm was discontinued on 6/5/15. Interventions for residents identified as having the potential to be affected: A facility audit was performed by the Director of Nursing (DON) and Quality Assurance Nurse (QA Nurse) on residents with orders for tab alarms and/or pressure alarm sensor pads to ensure interventions are in place and functional. Any resident noted without a tab alarm and/or pressure alarm sensor pad as ordered, had device replaced immediately as ordered. Licensed Nurses (LN) and Certified Nursing Assistants (CNA) were re-educated on the importance of ensuring care planned fall interventions are in place and functional as written in the comprehensive and/or interim care plan. Systematic Change: An audit will be performed by the Director of Nursing or Quality Assurance Nurse on residents with tab alarms and/or pressure alarms twice weekly for three (3) months	

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F 282	Continued From page 21 wheelchair with the pull tab alarm on the back of the wheelchair but not clipped to him while he was in an activity on 05/20/15 at 3:11 PM, at 3:45 PM while talking with activity staff, at 3:47 PM while there were no staff in the activity room, and at 4:06 PM as he sat in the doorway of his bedroom. Resident #18 was observed in his wheelchair with no alarm on the back of his wheelchair while he was in therapy, at 3:26 PM when therapy staff took him to an activity, at 3:43 PM while he was in his room watching television, and at 5:09 PM while he was watching television and staff filled his ice pitcher. On 05/21/15 at 5:09 PM, Nurse Aide (NA) #2 went into his room and filled Resident #18 ' s ice pitcher. NA #2 was asked at this time about any fall precautions, she replied that she was not his nurse aides and didn't usually work with him. She stated she thought he needed a bed alarm and 2 person assist to transfer. On 05/21/15 at 5:54 PM, Resident #18 was in his room, in his wheelchair, and a pressure alarm was observed in his wheelchair. On 05/22/15 at 2:30 PM, Nurse #1 stated Resident #18 was supposed to have a pull tab alarm not a pressure alarm. She then looked at his Medication Administration Record but it was not listed on there. On 05/22/15 at 2:33 NA #6 who cared for him during second shift on 05/20/15 and first shift on 05/21/15 stated that she was unaware that he needed any type of an alarm while in his wheelchair. A phone interview was conducted on 05/22/15 at 3:38 PM with NA #5, who was assigned to him on 05/20/15 during first shift, revealed she could not recall anything about an alarm for Resident #18. She further stated that she will look at the kardex	F 282	to ensure devices are in place and functional as written in the comprehensive and/or interim care plan. Newly hired Licensed Nurses (LN) and Certified Nursing Assistants (CNA) were re-educated on the importance of ensuring care planned fall interventions are in place and functional as written in the comprehensive and/or interim care plan. Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three months, the DON will report results of the alarm audits to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	

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F 282	Continued From page 22 for information if she was unfamiliar with a resident. She stated she was surprised he went to the activity on 05/20/15 as he rarely wanted out of bed. A phone interview was conducted on 05/22/15 at 3:45 PM with NA #1, who was assigned to Resident #18 on 05/21/15 during second shift. She stated that 05/21/15 was the first time she had worked with him and by the time she saw him on her shift, he was sitting on a pressure alarm. Interview with the Director of Nursing on 05/22/15 at 4:21 PM revealed she expected the alarm to be on as ordered and that the necessary information for alarms should be on the interim care plan accessible to the nurse aides.	F 282		
F 286 SS=D	483.20(d) MAINTAIN 15 MONTHS OF RESIDENT ASSESSMENTS A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to maintain the previous 15 months' assessments in the active record for 2 of 24 residents sampled for assessments (Residents #170 and #18). Findings included: 1) Resident #170 was admitted to the facility on 04/22/15. Diagnoses included dementia with behavioral disturbances and metabolic encephalopathy. Review of the medical record revealed no admission Minimum Data Set (MDS) was readily	F 286	F- 286 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's	6/19/15

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F 286	Continued From page 23 available for Resident #170. An interview was conducted with MDS Coordinator #1 and the Medical Records Director on 05/21/15 at 3:09 PM. MDS Coordinator #1 stated when she completed the MDS, she printed it and gave it to the Medical Records Director to be filed in the resident's chart. The Medical Records Director stated when she received a new MDS, she removed the previous MDS and filed it in a filing cabinet between the nurses' stations. She explained she then filed the new MDS in the resident's chart. Neither MDS Coordinator #1 nor the Medical Records Director could explain why Resident #170's admission MDS was not present in the chart or the filing cabinet. An interview was conducted with the Director of Nursing (DON) on 05/22/15 at 12:06 PM. She stated it was her expectation for 15 months of resident assessments to be kept readily accessible. The DON further explained Resident #170's admission MDS should have been available in the chart or the filing cabinet. 2) Resident #18 was admitted to the facility on 12/29/14. His diagnoses included pneumonia, acute respiratory failure, difficulty walking, dysphagia, muscle weakness, Diabetes, dementia, and anxiety state. The admission Minimum Data Set dated 01/05/15 coded him as having intact cognition, requiring extensive assistance for most activities of daily living skills, only being able to steady himself with human assistance, being frequently incontinent and having no fall history. There was no Care Area Assessment (CAA) related to this MDS in the file cabinet with the other MDSs and CAAs for other residents. On 05/21/15 at 3:09 PM, MDS coordinator MDS	F 286	allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. Interventions for affected resident: Resident #170 admission Minimum Data Set (MDS) was printed by MDS Nurse and placed in the resident medical record. Resident #18 admission Care Area Assessment (CAA) was printed by the MDS Nurse and placed in the resident medical record. Interventions for residents identified as having the potential to be affected: An audit was performed by the Medical Records Clerk and MDS Nurse(s) to ensure most current completed MDS and CAA of each facility resident is available in their medical chart and at least fifteen (15) months of each resident's MDS and CAA are readily available in the MDS filing cabinet at the Nurses' Station. Any MDS or CAA noted to not be accessible were immediately printed and filed as appropriate. Director of Nursing (DON) re-educated the facility Medical Records Clerk and MDS Nurse(s) on the importance of ensuring fifteen (15) months of assessments are readily available and accessible. Newly hired Medical Record Clerk and MDS Nurse(s) will be educated on the importance of ensuring fifteen (15) months of assessments are readily available and accessible.	

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F 286	Continued From page 24 Coordinator and Medical Records staff were interviewed. They stated that after staff complete the MDS and/or CAA, the MDS coordinator prints them off and gives them to the Medical Records staff to file them in the resident medical chart. The most recent MDS/CAA go into the chart and the overflow go into a filing cabinet so that 15 months are available for review. Interview with the MDS nurse on 05/21/15 at 3:58 PM, revealed that she did not think the CAAs got printed off when the facility changed to a new computer system. She provided the surveyor with the CAAs completed 01/09/15 after she printed them from the computer. On 05/22/15 at 12:04 PM, the Administrator stated it was his expectation that the completed 15 months of MDS and CAA were filed in the medical records/filing cabinet. The DON stated during interview on 05/22/15 at 12:06 PM that 15 months of assessments should have been either in the resident's medical chart or in the filing cabinet. On 05/22/15 at 7:13 PM, Nurse #2 stated she was unable to access the electronic MDS and CAA on the computer. She further stated that as far as she knew the MDS and CAA were on paper in the chart or in the filing cabinet. On 05/22/15 at 7:15 PM, Nurse #3 stated she was unable to pull up electronic MDS information. She further stated the information was in the medical record or filing cabinet at the nursing station. She stated she did not have access to the computer information.	F 286	Systematic Change: The Medical Records Clerk and/or Director of Nursing will audit (10) resident medical records weekly for three (3) months to ensure most recent completed MDS and CAA is located in the resident medical record and fifteen (15) months of completed MDS and CAA are readily available and accessible in the MDS filing cabinet located at the Nurses' Station. Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three months, the DON will report audit findings to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to	F 312		6/19/15

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F 312	Continued From page 25 maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review, family, and staff interviews the facility failed to wash residents hands before every meal who required assistance with activities of daily living for 1 of 3 residents sampled for activities of daily living (Resident #117). The findings included: Resident #117 was re-admitted to the facility on 03/13/15 with diagnosis which included cerebral vascular accident (stroke), aphasia (loss of ability to understand or express speech), and muscle weakness. Review of the most recent quarterly Minimum Data Set (MDS) dated 05/15/15 indicated Resident #117 had severe cognitive impairment for daily decision making and was incapable of making her needs known. Resident #117 required extensive assistance with 2 person physical assist for bed mobility and transfers, extensive assistance with 1 person physical assist for dressing, eating, and personal hygiene, and was totally dependent on staff for toileting and bathing with no documented behaviors or refusal of care. A review of care plans dated 05/15/15 revealed Resident #117 had a physical functioning deficit related to self-care impairment with approaches for staff to assist with activities of daily living (ADLs).	F 312	F- 312 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. Interventions for affected resident: Nursing staff was re-educated on washing resident #117's hands before each meal. Care plan was updated to reflect staff to provide assistance with washing Resident #117 hands prior to meals. Resident #117 care card was updated to reflect assistance with hand washing prior to meals. Interventions for residents identified as having the potential to be affected: An audit was conducted by the nursing staff on current residents and identified	

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F 312	Continued From page 26 On 05/19/15 at 8:23 AM, Nurse Aide (NA) #3 was observed to take Resident #117's breakfast meal tray into her room, set the tray on the over bed table, set up the breakfast meal in an order for Resident #117 to be capable to feed herself, and leave the room. NA #3 was not observed to wash the resident's hands before Resident #117 started to eat her breakfast meal. On 05/19/15 at 12:49 PM during an interview with Resident #117's family member, NA #3 was observed to set up the resident's lunch meal tray, the NA left the resident's room, and had not washed her hands before Resident #117 started to eat her lunch meal. The family member was observed to wash Resident #117's hands after the NA had left the room. The family member indicated there were numerous times when they had to wash Resident #117's hands because the nursing staff would come into the room, set up the meal tray, and leave the room. The family member pointed to a sign that they had placed on the wall above the resident's bed when she was admitted to the facility in hopes that it would be a reminder to the nursing staff to wash the resident's hands. The sign read in part "Please wash the resident's hands before each meal." The family member further indicated they had complained to the Director of Nursing (DON) related to the NAs being observed as to not wash Resident #117's hands before she would eat. On 05/21/15 at 5:50 PM, NA #2 was observed to take Resident #117's dinner meal tray into her room, set up the meal tray in order for the resident to feed herself, and then leave the resident's room without washing her hands.	F 312	those requiring assistance with washing hands. The Director of Nursing (DON) Staff Development Coordinator (SDC), Unit Manager (UM), and Minimum Data Set (MDS) Nurse will update the Resident Care Card and the Comprehensive Care Plan to reflect the amount of assistance required for each resident to accomplish this task Systematic Change: The SDC will re-educate the nursing staff on ensuring Activities of Daily Living (ADL) assistance is provided to the residents as outlined in the resident care plan. The education will include where the information indicating the amount of assistance needed for each resident is located. This education will be included in new hire orientation. The DON, SDC, UM, or MDS Nurse will observe staff serving meal trays randomly (breakfast, lunch and dinner). Audit will include observing five (5) residents three (3) times weekly for four (4) weeks, then two (2) times weekly for eight (8) weeks to assure compliance with assisting residents to wash their hands prior to meals. Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three months, the DON will report audit results to the Quality Assurance and Performance Improvement Committee. The Quality	

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F 312	Continued From page 27 During an interview on 05/21/15 at 5:56 PM NA #2 stated she was aware that the resident's hands were supposed to be washed prior to her meals. NA #2 further stated she was aware of the sign on the wall behind the resident's bed and she had no explanation as to why she had not washed Resident #117's hands before she started to eat. She indicated she was expected to wash all of the resident's hands before each meal but she would get busy and forget. During an interview on 05/22/15 at 9:06 AM Nurse #1 stated she would have expected the NAs to have washed Resident #117's hands before each meal. Nurse #1 further stated she expected the NAs to have washed all of the resident's hands before they would set up the meal trays in the resident's rooms. During an interview on 05/22/15 at 9:58 AM NA #3 stated she was aware of the sign on Resident #117's wall in her room and that Resident #117 was supposed to have her hands washed before every meal. NA #3 had no explanation as to why she had not washed the resident's hands before each meal. During an interview on 05/22/15 at 11:32 AM the Unit Manager (UM) stated she would have expected the NAs to have washed every resident's hands prior to the NAs setting up the resident's meal trays in their rooms. During an interview on 05/22/15 at 5:32 PM the Director of Nursing (DON) stated it was her expectation that all ADL care to be provided to the resident. She further stated she was unaware the resident's hands were not being washed prior to their meals.	F 312	Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	

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F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to check for placement of a gastrostomy feeding tube before flushing with water and before medication administration for 1 of 1 resident observed for administration of medications in a feeding tube during medication pass observations (Resident #137). The findings included: Resident #137 was admitted to the facility on 02/21/07 with diagnoses which included difficulty	F 322	F- 322 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged	6/19/15

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F 322	Continued From page 29 swallowing, traumatic brain injury, history of aspiration pneumonia (inhalation of food or fluids into the lungs), diabetes, depression and anxiety. The most recent Minimum Data Set (MDS) dated 05/20/15 indicated Resident #137 had short term and long term memory problems and had modified independence with daily decision making. A review of a physician's order dated 05/20/15 indicated to continue to check for tube placement prior to giving medication and water. During observations of medication administration on 05/22/15 at 9:28 AM Nurse #5 crushed medications into cups, mixed them with water and then poured liquid medications into cups at a medication cart and carried them into Resident #137's room. Nurse #5 did not have a stethoscope and disconnected the gastrostomy feeding tube from tubing that connected it to a feeding pump and used a syringe to insert 10 cubic centimeters (cc's) of water into the tube. She then poured each container of crushed and liquid medication into the syringe and flushed the tube with 10 cc's of water between each container of medication. After the medications had flowed into the tube Nurse #5 poured 10 cc's water into the syringe to flush the tube. During an interview on 05/22/15 at 9:37 AM with Nurse #5 she stated she was supposed to check placement of the gastrostomy tube by listening with a stethoscope before she flushed it with water or gave medications. She verified she did not check the tube for placement and knew she should have checked it before she gave the medications.	F 322	deficiencies cited have been or will be completed by the dates indicated. Interventions for affected resident: Licensed Nurse #5 was immediately re-educated by Director of Nursing on importance of checking gastrostomy tubes for placement prior to utilizing. Resident #137 gastrostomy tube was assessed via air bolus and auscultation utilizing a stethoscope and placement was confirmed by Staff Development Coordinator. A return demonstration was provided by Licensed Nurse #5. Interventions for residents identified as having the potential to be affected: Licensed Nurses were re-educated by Staff Development Coordinator on the importance of confirming placement of gastrostomy tubes prior to utilizing the gastrostomy tube. A demonstration of how to check gastrostomy tubes was provided by the Staff Development. A return demonstration was provided by all Licenses Nurses to ensure competency. Newly hired Licensed Nurses will be educated by the Staff Development Coordinator on the importance of confirming placement of gastrostomy tubes prior to utilizing the gastrostomy tube. A demonstration of how to check gastrostomy tubes will be provided by the Staff Development. A return demonstration will be required by all newly hired Licensed Nurses to ensure competency.	

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F 322	Continued From page 30 During an interview on 05/22/15 at 3:03 PM the Director of Nursing stated it was her expectation for nursing staff to check placement of gastrostomy feeding tubes by listening with a stethoscope prior to administering anything into the gastrostomy feeding tube which included food, water or medications.	F 322	Systematic Change: Random audits (across all shifts) will be performed by the Staff Development Coordinator of Licensed Nurses to ensure competency of checking gastrostomy tubes (G-tube) prior to utilizing tubes. Staff Development Coordinator will observe Licensed Nurse medication administration of three (3) residents with gastrostomy tubes weekly for a minimum of three (3) months to ensure Licensed Nurses are checking for placement prior to utilizing G-tube. Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three months, the Staff Development Coordinator will report results of the audits to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug	F 431		6/19/15

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F 431	Continued From page 31 records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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. 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 properly store two intravenous medications in a locked area for 1 of 2 nurses' stations reviewed for drug storage. Findings included: On 05/22/15 at 6:25 AM, an opaque blue bag was observed to be lying on the 200 and 400 hall nurses' station. The bag was unattended by any	F 431	F- 431 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state	

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F 431	Continued From page 32 staff member. Further investigation revealed the bag was sealed and had an inventory list affixed to it, detailing the contents as two intravenous antibiotics. Continuous observation of the bag was started at this time. On 05/22/15 at 7:13 AM, Nurse #6 was observed to open the bag and check the contents. The nurse opened the blue bag and took out two smaller silver bags with orange stickers affixed to the front, indicating the medications should have been refrigerated. Both silver bags were insulated and had a cold pack inserted with the intravenous antibiotics. Upon touching, both cold packs were no longer solid but still cool to the touch. Nurse #6 stated the medications should have been stored properly once they were received from the pharmacy. The nurse immediately notified the Director of Nursing (DON), who instructed the nurse to place a sign on the medications saying not to use them. An interview was conducted with the DON on 05/22/15 at 8:20 AM. She provided a pharmacy report where a nurse had signed she had received the medications on 05/22/15 at 1:40 AM. She stated the medications should have been stored properly when they were received from the pharmacy. The DON further explained the pharmacy had stated the medications could be left unrefrigerated for up to 48 hours before they had to be disposed of.	F 431	regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. Interventions for affected resident: Medications were immediately locked in medication room. No residents were affected as the medications left at the nurses' station were deemed safe per Omnicare Pharmacy. The Director of Nursing (DON) contacted the pharmacy for further instructions related to the medications being left out of the refrigerator. The Pharmacist advised that the medications were safe out of the refrigerator for 48 hours as long as they were refrigerated at that time or used up immediately. Interventions for residents identified as having the potential to be affected: The Staff Development Coordinator (SDC) re-educated the Licensed Nurses on the facility's protocol for receiving and storing medications delivered by the pharmacy. The education included placing medications indicating the need for refrigeration in the refrigerator when they are received. All medications are to be locked in the medication carts or in the medication room immediately upon receipt. Medications are to be supervised by a licensed nurse or locked up at all	

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F 431	Continued From page 33	F 431	times. Systematic Change: The DON, SDC, Unit Manager (UM) or Designee will monitor each nursing station three (3) times weekly for 4 weeks, then two (2) times weekly for 8 weeks to monitor for compliance with medications being properly stored. Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three months, the DON will report audit results to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;	F 441		6/19/15

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	345159	A. BUILDING _____ B. WING _____	C 05/22/2015

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F 441	Continued From page 34 (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to disinfect a blood glucose machine between residents according to manufacturer's recommendations for 2 of 2 finger stick blood sugars observed during medication pass (Resident #135 and #63). The findings included: A review of a facility document titled guidelines for disinfecting blood glucose machines that was not	F 441	F- 441 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of	

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F 441	Continued From page 35 dated indicated to wipe blood glucose machines down with a germicidal wipe. A review of manufacturer's instructions for the germicidal wipes indicated to wipe by thoroughly wetting the exterior of the equipment or surface to remain visibly wet for 3 minutes and let air dry. During continuous observations on 05/22/15 at 11:46 AM Nurse #4 picked up a blood glucose machine from the top of a medication cart and carried it into Resident #135's room and performed a finger stick blood sugar. Nurse #4 then left Resident #135's room and walked back to the medication cart in the hallway and took a germicidal wipe from a container and wiped once across the front side of the blood glucose machine and discarded the wipe into a trash can. She then took another germicidal wipe from a container and wiped once across the back of the blood glucose machine and discarded the wipe into a trash can. She then laid the blood glucose machine on top of a dry washcloth on top of the medication cart and wrote a note on Resident #135's medication administration record. Nurse #4 then picked up the blood glucose machine and walked into Resident #63's room and performed a finger stick blood sugar. Nurse #4 then left Resident #63's room and walked back to the medication cart in the hallway and took a germicidal wipe from a container and wiped once across the front of the blood glucose machine and discarded the wipe in the trash can. She then took another wipe from the container and wiped once across the back of the blood glucose machine and discarded the wipe into a trash can. She then laid the blood glucose machine on top of a dry washcloth on top of the medication cart.	F 441	correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. Interventions for affected resident: No residents were affected by this alleged deficient practice. Interventions for residents identified as having the potential to be affected: All current residents have the potential to be affected. Staff Development Coordinator performed re-education to Licensed Nurses concerning following manufacturer recommendations for glucometer cleaning. Licensed Nurses provided return demonstration of proper procedure in disinfecting glucometer after use utilizing manufacturer recommendations. Systematic Change: Director of Nursing or Staff Development Coordinator will randomly observe five (5) Licensed Nurses weekly for three (3) months to validate proper procedure for disinfecting glucometer per manufacturer recommendations after use. Newly hired Licensed Nurses will be educated with return demonstration of glucometer cleaning to validate proper procedure for disinfecting glucometer per manufacturer. Monitoring of the change to sustain	

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F 441	Continued From page 36 During an interview on 05/22/15 at 11:55 AM with Nurse #4 she stated blood glucose machines were supposed to be cleaned after each finger stick blood sugar with germicidal wipes. She stated nurses were expected to wipe down one side of the glucose machine and then down the other so that it was visibly wet and it should dry for 3 minutes and then it could be used again. She further stated she did not know how long the blood glucose machine should remain wet but it was supposed to be placed on a clean barrier after it was used and it was supposed to air dry for 3 minutes. During an interview on 05/22/15 at 3:03 PM the Director of Nursing stated it was her expectation that blood glucose machines should be cleaned according to manufacturer's recommendations. She explained nursing staff had been in-serviced regarding cleaning of blood glucose machines and they had been instructed to wipe them with a germicidal wipe and allow them to air dry for 3 minutes but they had not been instructed to keep the blood glucose machine visibly wet for the required time according to the manufacturer's instructions.	F 441	system compliance ongoing: Monthly for a minimum of three months, the DON will report glucose disinfection observation audits to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance	F 520		6/19/15

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F 520	Continued From page 37 committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facilities Quality Assessment and Assurance Committee failed to maintain a system which relates to the accuracy of assessments that the committee put into place in January of 2014. This was a recited deficiency which was originally cited in January of 2014 on the facilities annual certification and complaint survey. The deficiency was in the area of accuracy of the Minimum Data Sets (MDSs). The continued failure of the facility during the two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referenced to: 1a. F278: Accuracy of Assessment: Based on record review and staff interview, the facility failed	F 520	F- 520 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. Interventions for affected resident: Resident #132 Minimum Data Set (MDS) was updated to reflect Pre-Admission	

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F 520	Continued From page 38 Accurately complete the Minimum Data Sets (MDSs) for 2 of 24 sampled residents who's MDSs were reviewed for accuracy. Resident #132's MDS did not reflect the Pre-admission Screening and Resident Review (PASRR) Level II and Resident #33's MDS did not reflect the respite stay in the facility. During an annual certification and complaint investigation survey of January, 2014 the facility was cited for F 278 for failing to accurately code the Minimum Data Set (MDS) to reflect impaired range of motion for 1 of 2 residents reviewed for activities of daily living (Resident #131) and hospice care for 1 of 1 resident reviewed for hospice care (Resident #114). During an interview on 05/22/15 at 6:53 PM the Administrator stated his expectation was for the facility to have completed the random audits to measure the effectiveness of their action plans which had been driven by the plan of correction that was developed as a result of the previous survey of January 2014. The Administrator indicated he was unaware there was a problem and that the QAA systems that were implemented in January 2014 were not followed and/or monitored.	F 520	Screening and Resident Review (PASSR) Level II Resident #33 MDS was updated to reflect Respite Care Services Resident #131 MDS was updated to reflect impaired range of motion Resident #114 MDS was updated to reflect Hospice Care Services Interventions for residents identified as having the potential to be affected: Re-education was provided to the facility Quality Assessment and Assurance Committee (QA&A Committee) by the Quality Assurance (QA) Nurse. Education included importance of maintaining an effective QA&A Committee. Education emphasized ensuring the QA &A Committee oversees and identifies all efforts that improve the quality of care in the facility by monitoring performance measures, directing improvement actions by correcting and sustaining compliance and evaluating the effectiveness of quality management activities. Systematic Change: Random audits will be completed by the facility MDS Consultant or Designee to validate accuracy of assessments. Audits will be completed on eight (8) resident MDS assessments monthly for twelve (12) months. Audits will include thoroughly reviewing for appropriate and accurate coding. Monitoring of the change to sustain	

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F 520	Continued From page 39	F 520	system compliance ongoing: Monthly for a minimum of twelve (12) months, the Director of Nursing will report audit results to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the twelve (12) months.	