STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345516	A. BUILDING _____ B. WING _____	C 07/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONOVER NURSING AND REHAB CTR	920 4TH STREET SOUTHWEST CONOVER, NC 28613

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interviews, and staff interviews, the facility failed to promote the dignity of 1 of 4 residents sampled for dignity. Resident #29 was interrupted during an interview by staff to apply cream to her legs without affording her the opportunity for staff to return later. The findings included: Resident #29 was most recently admitted to the facility on 10/21/14. Her diagnoses included acute pancreatitis, acute renal failure, diabetes, and limb swelling. A significant change Minimum Data Set dated 05/07/15 coded her with intact cognition (scoring a 9 out of 15 on the brief interview for mental status), having little energy for the previous 12 to 14 days, having no behaviors, requiring extensive to total assistance with activities of daily living skills, and being non-ambulatory. On 06/29/15 at 2:33 PM, the surveyor was conducting an interview with Resident #29. Nurse #1 knocked on the door, entered and told Resident #29 she was going to put cream on her feet and legs. Nurse #1 did not ask Resident #29 if this was a good time, if she was interrupting, or	F 241	F241 1.Nurse #1 was interviewed and adamantly insisted that Resident #29 gave her permission by indicating it was ok to provide the treatment to her legs. Nurse was educated on ensuring dignity for all residents while administering care. 2.All current residents were interviewed on July 21, 2015 to ensure they are provided dignity while care is administered. There were no other complaints. 3.Nurses were inserviced July 22, 2015 on ensuring that they provide dignity to all residents when providing treatment including getting permission from residents prior to providing treatments in front of others including state surveyors. 4.Director of Nursing or designee will interview 5 residents from each hall (totaling 20 residents) per month for 3 consecutive months to ensure dignity is being preserved during care. Results will be monitored in Quality Assurance Committee.	7/30/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/24/2015

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if she could apply the cream while the surveyor was in the room. Nurse #1 proceeded to apply cream to her legs and feet. When the treatment was over, the surveyor asked Resident #29 about the interruption. Resident #29 stated that the nurse usually came in and told her what she was going to do and did it. Resident #29 stated she would have preferred to be asked if it was a good time to apply the cream to her legs.

On 06/29/15 at 3:01 PM, Nurse #1 was interviewed. Nurse #1 stated she was just coming down the hall and went into the resident's room, "jumped on it" and did the treatment. She further stated she should have asked Resident #29 if it was ok to do the treatment then. Nurse #1 apologized.

On 07/02/15 at 9:03 AM the first shift nursing supervisor was interviewed. She stated that when a visitor was in a resident's room, she expected staff to ask the resident their preference regarding if the time was ok to give care and/or if the resident wanted the visitor to step out of the room. The nurse supervisor further stated Nurse #1 should have told the resident what she wanted to do and ask Resident #29 if she wanted the treatment to be done then or later.

On 07/02/15 at 9:16 AM, the Administrator asked the surveyor to discuss the incident with Nurse #1 again.

Resident #29 was interviewed a second time on 07/02/15 at 9:27 AM. Resident #29 recalled the incident when Nurse #1 put cream on her legs when the surveyor was present. Resident #29 stated she could not recall details in terms of if Nurse #1 specifically asked if it was a good time

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F 241	Continued From page 2 to apply the treatment to her legs. She stated Nurse #1 always just came in and stated what she was going to do and just did it. Resident #29 stated Nurse #1 does not ask what her preference is in terms of the timing of the treatment. Resident #29 stated she did not want to interfere with staff schedules so she accepted care whenever staff came to provide it. A second interview was conducted with Nurse #1 on 07/02/15 at 12:08 PM. Nurse #1 stated she had the cream for Resident #29's legs in her pocket and when she entered the resident's room, she told the resident she had "the cream for your legs is that ok?" Nurse #1 said the resident responded 'ok'. Upon further interview on 07/02/15 at 12:08 PM, Nurse #1 stated she should have asked Resident #29 if it was alright to apply the cream in the presence of the surveyor. She also stated she did not know the surveyor was in the room when she entered the room as the curtain was pulled. She stated she did not know Resident #29 was in the midst of an interview. Interview with the Director of Nursing on 07/02/15 at 5:14 PM revealed that if Resident #29 did not want the treatment done at the time the nurse entered to do it, the resident would have said so.	F 241		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced	F 253		7/30/15

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F 253	Continued From page 3 by: Based on observations, resident and staff interviews, and record review, the facility failed to maintain wood doors free of scrapes and rough edges, walls without scrapes and exposed plaster, and keep door frames painted. This was observed on 3 of 4 hallways. (Halls 100, 200 and 300). The findings included: Resident rooms were observed with scraps on the walls exposing dry wall, scrapes on the wood doors exposing raw rough wood, and scraped paint on the lower half of the metal door frames as follows: a. Room 102: The lower third of the wood door to the room had chipped edges with 5 chunks of chipped wood missing exposing the lighter raw wood under the chips. The lower third of the metal frames of the bedroom and bathroom doors had scraped paint exposing the metal. The bedroom wall, across from bed b, was scraped where a chair had set. This was observed on 06/30/15 at 3:23 PM, on 07/01/15 at 2:52 PM, and on 07/02/15 at 11:41 AM. b. Room 106: There were small gashes of scraped paint by bed b exposing the dry wall underneath. The lower third of the metal door frame into the room had the paint scraped off exposing metal. This was observed on 06/30/15 at 3:20 PM, on 07/01/15 at 2:53 PM, and on 07/02/15 at 11:41 AM. c. Room 108: The walls by both bed a and bed b had scratches exposing the wall board under the paint. The worst being 1 foot by 1 foot square in	F 253	F253 1.All environmental issues identified were repaired in rooms 102, 106, 108, 202, 210, 303, 304, 305, 306, 307, 310, 311, 313, 314, and 316. 2.Maintenance Director assessed all other patient rooms in need of potential repairs to doors, door frames, and drywall and completed all identified repairs by 7/28/2015. 3.System change was implemented requiring Maintenance Director to complete quarterly preventative maintenance rounds to identify need for repairs to doors, door frames, and drywall using the Maintenance Inspection Checklist. 4.Director of Maintenance will monitor all patient rooms to ensure all doors, door frames, and drywall are in good repair once monthly for 3 consecutive months. Results will be monitored in Quality Assurance Committee.	

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size. This was observed on 06/29/15 at 2:23 PM, 06/30/15 at 3:22 PM, on 07/01/15 at 2:54 PM, and on 07/02/15 at 11:42 AM.

d. Room 202: There was a 1 foot by 1 foot scrape on the wall by the head of bed b. The metal door frame had chipped paint exposing the metal underneath. There were scraped missing wood chunks on both edges of the wood door entering the room, exposing the raw wood. This was observed on 07/01/15 at 6:05 AM and 2:51 PM and on 07/02/15 at 11:43 AM.

e. Room 210: The inside of the bathroom door had scrapes at least 1 inch wide across the bottom of the door exposing raw wood. This was observed on 07/01/15 at 5:18 AM and 2:51 PM and on 07/02/15 at 11:43 AM.

f. Room 303: The bedroom door was scraped and had chunk of wood missing on the edges. The door frame was scraped of paint exposing the metal. The wall by bed b had scraped wall board. This was observed on 06/30/15 at 3:54 PM, on 07/01/15 at 2:49 PM, and 07/02/15 at 11:45 AM.

g. Room 304: The bedroom wood door was scraped along the bottom with chunks on the inside edge exposing the wood on the lower half of the door. The paint on the door frame was scraped exposing the bare metal. The wall by the head of bed b had a 3 foot long scrape exposing the wall board. The bathroom door had a 3 inch by half inch chunk chipped off just below the handle exposing rough, raw wood. This was observed on 06/29/15 at 2:14 PM, 06/30/15 at 3:38 PM, 07/01/15 at 2:48 PM, and on 07/02/15 at 11:45 AM.

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h. Room 305: On the wall by bed b there were chunks and scrapes by the bed. Bed a had a large scraped area by her bed with deep gashes into the dry wall with peeling areas of wall board in the middle. The paint on the frame around the bedroom door was scraped exposing bare metal. The door to the bedroom was scraped at the edges by the hinge and about 3 inches across the door exposing raw wood. This was observed on 06/29/15 at 2:56 PM, 06/30/15 at 3:37 PM, on 07/01/15 at 2:47 PM, and on 07/02/15 at 11:47 AM. The resident in this room, assessed on the annual Minimum Data Set dated 04/02/15 as having intact cognition stated on 07/02/15 at 12:04 PM that she would "not hardly" have walls in her home in this shape and stated it made the place look "raggy".

i. Room 306: The lower third of the door frame into the room was scraped of paint exposing the metal underneath. There were chunks of wood missing off the edges of the wood door half way up the hinge side of the door. This was observed on 06/30/15 at 3:35 PM, on 07/01/15 at 2:47 PM, and on 07/02/15 at 11:46 AM.

j. Room 307: The wood bedroom door had scrapes and missing chunks in the wood and the lower third of the door frame had scraped paint exposing the metal underneath. The wall by bed b had 4 long 3-6 inch by 2 inch wide gashes with missing blue pain and exposed drywall. This was observed on 06/29/15 at 3:05 PM, 06/30/15 at 3:42 PM, on 07/01/15 at 2:46 PM, and on 07/02/15 at 11:46 AM.

k. Room 310: The lower third of the door frame was scraped of paint exposing the metal

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underneath. There were chunks of wood missing from the edge of the bedroom door near the hinges exposing raw wood with a 3 inch chunk of missing wood from a corner leaving a rough raw area. This was observed on 06/30/15 at 9:41 AM and 3:43 PM, on 07/01/15 at 2:46 PM, and on 07/02/15 at 11:49 AM.

l. Room 311: The door frame was scraped of paint exposing the metal on the lower third of the frame. The bedroom door had scraped missing chunks of wood along the edges exposing rough raw wood. The bathroom door had 3 long scraped areas exposing raw wood. This was observed on 06/29/15 at 3:11 PM, on 06/30/15 at 3:44 PM, on 07/01/15 at 2:45 PM, and on 07/02/15 at 11:50 AM.

m. Room 313: The door frame to the room was scraped of paint exposing the metal, the lower half of the wood door was scraped with missing chunks of wood and rough spots and there was a long scrape one third up form the floor across the wood door exposing raw wood. The wall over the bed was scraped with 6 to 8 areas of peeled, scraped wall board. This was observed on 06/29/15 at 3:11 PM, 06/30/15 at 3:46 PM, on 07/01/15 at 2:45 PM, and on 07/02/15 at 11:51 AM.

n. Room 314: The wall by the head of bed b had several scrapes of missing paint covering approximately a foot. The wood door to the bedroom was scraped with missing chunks on the edges of the door exposing wood and rough areas. The lower third of the metal frame was chipped of paint exposing the metal underneath. This was observed on 06/29/15 at 3:00 PM, on 06/30/15 at 3:49 PM, on 07/01/15 at 2:44 PM,

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and on 07/02/15 at 11:51 AM. A visitor was in the room at this final observation who reported the room has looked the same for 4 to 5 months.

o. Room 316: There were scrapes on the wall covering approximately 3 feet, exposing drywall by bed a. The door had 2 large scrapes on the lower third with rough exposed wood. The door frame was chipped and exposed metal was observed. This was observed on 06/29/15 at 3:15 PM, 06/30/15 at 3:52 PM, on 07/01/15 at 2:43 PM, and on 07/02/15 at 11:52 AM.

On 07/02/15 at 9:34 AM the Maintenance Director was interviewed. He stated that the preventative maintenance program he had in place was based on life safety code requirements. He stated he relied on work orders by staff to fix what things are in need of repair or by word of mouth. Regarding the wall, door frames and the wood doors, he stated those things needed constant attention and were on no check list for routine review. He stated the facility has ordered vinyl boards to use on bedroom walls, corners and doors. He provided the surveyor with a quote for 15 corner guards, 15 sheets of vinyl and adhesive. He stated he ordered these items 06/25/15. Follow up interview on 07/02/15 at 3:28 PM with the Maintenance Director revealed that instead of patching and painting, the facility wanted a more permanent solution so the vinyl was being ordered. The Maintenance Director was unable to tell the surveyor the last time he painted door frames. He further stated he had no systematic plan of the order he was going to repair or replace the bedroom doors. He stated he ordered 2 doors 1-2 days ago but could not say how long it would be for the instillation of the doors or which doors were to be replaced or just

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F 253	Continued From page 8 covered in vinyl. Upon further discussion, the Maintenance Director had no plan as to which areas were to be prioritized to fix as it changed on a daily basis nor any time frame to complete the door and wall repairs.	F 253		
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 material and false statement. This REQUIREMENT is not met as evidenced	F 278		7/30/15

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F 278	Continued From page 9 by: Based on record review and staff interview, the facility failed to accurately assess falls for 1 of 3 residents sampled for falls. (Resident #126). The findings included: Resident #126 was admitted to the facility on 09/19/14 with diagnoses including cerebral vascular disease, atrial fibrillation, history of falls, encephalopathy and peripheral vascular disease. The admission Minimum Data Set (MDS) dated 09/26/14 coded Resident #126 as having intact cognition (scoring a 9 out of 15 on the Brief Interview for Mental Status (BIMS)), being nonambulatory, requiring extensive assistance with bed mobility and transfers and having balance problems in which he needed human assistance to stabilize during transitions. He was also noted to have had a fall before admission to the facility. Review of the incident logs revealed on 03/16/15 at 10:43 PM, Resident #126 experienced a fall with no head injury. The incident report noted the resident slid from the wheelchair to the floor and was found sitting on his buttocks. This report was signed off as being reviewed by the first shift supervisor on 03/17/15 with the addition of dycems (nonskid pad) to be placed both under and over the chair cushion. There was no corresponding nursing note to this fall. A nursing note dated 03/17/15 at 3:11 AM noted there was no signs or symptoms of injury from the previous fall. The quarterly MDS dated 03/20/15 coded	F 278	F278 1.Upon discovery of coding error related to fall on Resident #126 MDS ARD 3/20/2015 the MDS nurse immediately completed a correction request indicating that a fall occurred and submitted on 7/2/2015 according to CMS RAI Manual guidelines for correcting coding errors. Facility investigation revealed that fall was reported to MDS accurately and fall care plan interventions were completed. Error determined to be coding error only. MDS nurse was immediately educated on the importance of MDS accuracy and being careful not to make any mistakes in coding. 2.A total review of MDS accuracy related to falls was completed on 7/21/15 for all residents having a fall within the last quarter. No errors in fall coding were discovered for any other resident. 3.In order to prevent coding errors, a system change was implemented requiring the MDS nurse to print the incident log for each resident upon completing their assessment to ensure that falls are coded accurately. The incident log will be attached to the MDS worksheet. 4.Director of Nursing or designee will monitor 1 MDS per week for 3 consecutive months to ensure accurate coding of falls on the MDS and incident log is attached to the MDS worksheet.	

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F 278	Continued From page 10 Resident #126 has having had no falls since the previous assessment. On 07/02/15 at 9:55 AM the MDS nurse was interviewed. She stated that she collected MDS information from the computer, nursing notes, looking and talking to the resident, and getting information from morning meetings. As she reviewed the MDS dated 03/20/15, she confirmed that she had not correctly coded Resident #126's fall on the MDS. She was unable to state how this information was missed when she completed the MDS. In the midst of this conversation, the MDS Coordinator joined in and stated there was nothing in the nursing notes related to the fall on 03/16/15. On 07/02/15 at 5:13 PM, the Director of Nursing stated during interview that she expected the MDS to be coded accurately.	F 278	Results will be monitored in Quality Assurance Committee.	
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to initiate restorative services for 1 of 3 residents sampled for rehabilitation services. Resident #141 was not started on a restorative plan until over a month following a referral and subsequently not placed on the referred ambulation program.	F 311	F311 1.Restorative Director immediately began restorative services and completed care plan upon discovery of the restorative referral on her desk on 5/29/2015 for Resident #141. Restorative Director was educated on the importance of quickly	7/30/15

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F 311	Continued From page 11 The findings included: Resident #141 was admitted to the facility on 12/30/14. Her diagnoses included cerebral vascular accident, urinary tract infection, dementia, muscle weakness and chronic airway obstruction. She was hospitalized on 03/14/15 and readmitted to the facility on 03/26/15 with pneumonia. The admission Minimum Data Set (MDS) dated 04/02/15 coded Resident #141 with severely impaired cognition, having no behaviors, requiring extensive assistance with bed mobility and transfers, being nonambulatory, needing human assistance with balance during transitions, and receiving occupational and physical therapies. Review of physical therapy (PT) notes revealed Resident #141 started PT on 03/27/15 due to difficulty walking. The last PT note dated 04/22/15 noted a plan to discontinue skilled services and refer to a functional maintenance program for gait analysis, safety training and standing balance activity. A Restorative Referral was completed on 04/24/15 by the physical therapist and stated that the start date of the restorative program was 04/25/15. Per this form, Resident #141's current functional status was gait training greater or equal to 100 feet with a rolling walker with care giver assistance and verbal cues. The program was for gait training and range of motion to bilateral lower extremities and bilateral upper extremities exercises. This restorative referral was signed by 2 restorative nursing aides (RNA #1 and #2) on 04/24/15 indicating they received training on Resident #141's restorative program.	F 311	starting restorative programs upon referral to ensure residents are given appropriate treatment and services to maintain or improve his or her abilities. 2.A thorough review was completed of any resident discharged from therapy within the last 3 months to ensure therapy referrals for restorative programs were completed timely. Restorative programs were implemented timely for all other residents reviewed. 3.A new handoff form and procedure was developed to ensure that therapy referrals for restorative programs are received and completed by the Restorative Director. Therapy will first notify the Restorative Director of a referral in writing. Restorative Director will create restorative program and care plan, sign the referral form and return copy to therapy referral source. 4.Director of Nursing or designee will monitor 100% therapy referrals to restorative services for 3 consecutive months to ensure that restorative services are initiated timely following therapy referrals. Results will be monitored in Quality Assurance Committee.	

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The quarterly MDS dated 05/24/15 coded Resident #141 with severely impaired cognition, having no behaviors, being nonambulatory, requiring extensive assistance with bed mobility and transfers, and receiving no skilled therapies or restorative services.

A restorative plan of care was developed for transfers on 05/29/15 with a goal for her to perform at least 5 sit to stand transfer exercises at the rail with rest periods, verbal cues and limited assistance by 08/26/15. Interventions included sit to stand transfer exercises at least 6 times per week. A restorative plan of care was developed for active range of motion on 05/29/15 with a goal for Resident #141 to participate and perform 10 repetitions times 2 sets to all extremities with verbal cues by 08/26/15. Interventions were to provide active range of motion 6 times per week. There was no plan of care for ambulation or gait training.

Review of restorative documentation revealed Resident #141 did not receive restorative services until 05/29/15. The documentation revealed she received range of motion exercises and transfer training but no ambulation.

On 07/01/15 at 12:43 PM, RNA #3 stated Resident #141 received active range of motion and transfers. RNA #3 stated she needed assistance to stand.

On 07/02/15 at 11:39 AM the Rehabilitation Director stated normally restorative services picked a resident up immediately upon skilled therapy discharge. On 07/02/15 at 12:29 PM the Rehabilitation Director provided the restorative

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referral which indicated PT trained restorative staff on 04/24/15 to take over Resident #141's care which included ambulation and range of motion exercises.

On 07/02/15 at 12:38 PM the Restorative Director was interviewed. The Restorative Director stated that referrals for restorative services came from skilled therapy, sometimes verbally, however, she did not initiate the program until a written referral was received. After restorative aides signed they have been trained by therapy on the specific program, then she developed the written care plan. She stated that a restorative program and services did not begin until 05/29/15. She further stated that there was a lot going on in the facility at the time the referral came to her and when she found the referral on her desk, she developed the care plan and started services. Restorative Director further stated that because of the delay between skilled services ending and restorative services starting, she did not care plan an ambulation program as therapy had indicated because she wanted to be sure Resident #141 was strong enough to ambulate.

On 07/02/15 at 12:57 PM RNA #2 stated she was trained on the restorative program on 04/24/15 but did not begin the program until the Restorative director puts it in the computer, i.e. the care plan.

On 07/02/15 at 2:37 PM, nurse aide (NA) #3, who was providing care this date, stated Resident #141 did not walk.

During interview on 07/02/15 at 5:16 PM, the Director of Nursing stated she expected restorative services to be implemented as soon

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F 311	Continued From page 14 as possible after a referral was made by therapy.	F 311		
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 maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to thoroughly clean stool off a resident during incontinence care for 1 of 1 resident observed for incontinence care. (Resident #29). The findings included: Resident #29 was re-admitted to the facility on 10/21/14 with diagnoses which included kidney failure, diabetes, osteoarthritis, depression, anxiety, heart failure and a stroke. A review of a significant change Minimum Data Set (MDS) dated 05/07/15 indicated Resident #29 was moderately impaired in cognition for daily decision making, required extensive assistance for toileting and hygiene, was frequently incontinent of bladder, and was always incontinent of bowel. A care plan meeting was held reviewing the care plans on 05/01/15. A review of a care plan titled incontinence care indicated to give perineal care when Resident #29 was incontinent. During an observation of incontinence care on	F 312	F312 1.NA#1 and NA#2 immediately provided additional pericare to resident #29. NA#1 and NA#2 were immediately educated on providing thorough pericare. 2.Staff Development Coordinator immediately assessed all other incontinent residents for appropriate pericare on 7/1/2015. No other issues with pericare were identified. 3.CNAs were inserviced on 7/22/2015 regarding providing thorough incontinent care. 4.Director of Nursing or designee will observe 5 CNAs per month on various shifts for 3 consecutive months to ensure proper return demonstration of pericare. Results will be monitored in Quality Assurance Committee.	7/30/15

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07/01/15 at 11:11 AM Resident #29 was in bed and was turned on her right side by NA #1 and NA #2. Resident #29's brief was removed and she had a bowel movement. NA #1 used individual peri wipes to wipe stool from Resident #29's bottom. Resident #29 still had a small amount of brown stool on her bottom and NA #2 asked Resident #29 if she still needed to have a bowel movement and Resident #29 stated no. A clean brief was placed under Resident #29, she was turned to her back, then turned slightly to her left side to place a pillow at her back and the sheet was pulled up. NA #1 removed her gloves and stepped back from the side of the bed but was stopped by the surveyor and questioned if incontinence care was finished. NA #1 stated yes but when questioned if all of the stool had been cleaned from Resident #29's bottom, NA #1 and NA #2 put on gloves, turned Resident #29 on her right side, removed the brief, and at that time, Resident #29 was observed with stool on her bottom. NA #1 used individual peri wipes and cleaned the stool off Resident #29's bottom, placed a clean brief under Resident #29, turned her slightly to her right side, placed a pillow behind her back and covered her with a sheet.

During an interview on 07/01/15 at 11:23 AM with NA #1, she confirmed she thought Resident #29 had finished having a bowel movement but when asked if she was clean she wasn't sure so they turned her again to check and found she still had stool on her.

During an interview on 07/01/15 at 11:25 AM with NA #2 she stated they should have made sure Resident #29 was clean before they placed a pillow at her back and pulled the sheet up over the resident. NA #2 verified when Resident #29

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F 312	Continued From page 16 was turned again and the brief was removed she still had a stool on her bottom. During an interview on 07/01/15 at 11:36 AM with the Director of Nursing (DON) she stated it was her expectation for incontinence care to be done after each incontinent episode and she expected for staff to get the resident clean. She explained Resident #29 had redness on her bottom and was at risk for skin breakdown and staff should have made sure she was clean so her skin didn't break down.	F 312		
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 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,	F 431		7/30/15

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F 431	Continued From page 17 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, nursing staff and pharmacist interviews the facility failed to securely store medications in 1 of 2 medication rooms (400 hall). The findings included: The facility's storage medications policy was reviewed. The policy dated 04/2007 included the following statement, "The facility shall store all drugs and biologicals in a safe, secure, and orderly manner." The #9 Policy Interpretation and Implementation revealed, "medications requiring refrigeration must be stored in the refrigerator located in the drug room at the nurses' station or another secured location." On 07/01/15 at 4:05 PM, the 400 hall medication storage area had a small refrigerator located in the staff bathroom. The refrigerator, bathroom door and door to the outer hallway were not locked. Medications not secured in the refrigerator included Humalog insulin, Acetaminophen suppository 650 mg, Tuberculin 5 TU/0.1 ml and Bisacodyl 10 mg suppository.	F 431	F431 1.The medications stored in the refrigerator located in the nurse station bathroom were immediately removed. The refrigerator was also immediately and permanently removed from the area. 2.There were no other medication storage areas with unsecure medications in the facility. 3.Nurses were inserviced on 7/22/2015 regarding securely storing medications. 4.Director of Nursing or designee will monitor all medication storage areas once weekly for 3 consecutive months to ensure that medications are securely stored in locked compartments. Results will be monitored in Quality Assurance Committee.	

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F 431	Continued From page 18 On 07/01/15 at 4:05 PM, the day shift Nurse #3 stated that medication refrigerator was in the staff bathroom. It did not have a lock on it. The hallway door to the bathroom was not locked and the bathroom door was not kept locked. On 07/01/15 at 4:05 PM, the Evening Nurse #2 stated that the room where the medication refrigerator was located was a staff bathroom which was used only by staff. The refrigerator was not locked. She stated the hallway door to the bathroom and the bathroom door were not kept locked. On 07/01/15 at 4:10 PM an interview with the consultant pharmacist was conducted. She stated that her expectation was that all medications were securely stored. On 07/02/15 at 3:30 PM an interview was conducted with the Director of Nursing. She stated her expectations were that all medications were stored securely and narcotics were secured and locked.	F 431		
F 520 SS=E	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 committee meets at least quarterly to identify issues with respect to which quality assessment	F 520		7/30/15

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F 520	Continued From page 19 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 observations, record reviews, and staff and resident interviews, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in May 2014. This was for one recited deficiency which was originally cited in February 2013 on a recertification survey, again on a recertification and complaint survey in April 2014 and again on the current recertification survey. The deficiency was in the area of medication labeling and storage. Two additional recited deficiencies were originally cited in April 2014 on a recertification and complaint survey and again on the current recertification and complaint survey. The deficiencies were in the areas of activities of daily living and Quality Assessment and Assurance Committee. The facility's continued failure to implement and maintain procedures from a Quality Assessment and Assurance Committee, during three federal surveys of record, show a pattern of the facility's	F 520	F520 It is the policy and practice of the facility to maintain a quality assessment and assurance committee (QAA) consisting of the outlined members that meet monthly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action designed to correct identified quality deficiencies. The facility has policies and procedures designed to maintain these goals. Quality assurance monitoring, physician reviews, consultant reviews, and staff training are examples of the many components utilized. 1. A) F312: Implemented additional audit where the Director of Nursing or designee will observe 5 CNAs per month on various shifts for 3 consecutive months to ensure	

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F 520	Continued From page 20 inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referred to: 1 a. F 312 Activities of Daily Living: Based on observation, record review and staff interviews the facility failed to clean stool off a resident during incontinence care for 1 of 1 resident observed for incontinence care. (Resident #29). F 312 was originally cited during the April 11, 2014 recertification survey for failure to provide oral care for residents who required extensive assistance for activities of daily living. On the current recertification and complaint survey the facility was again recited for failure to clean stool off a resident during incontinence care. b. F 431 Medication Labeling and Storage: Based on observations, nursing staff and pharmacist interviews the facility failed to securely store medications in 1 of 2 medication rooms (400 hall). F 431 was originally cited during the February 20, 2013 recertification survey for failure to discard expired medications in 2 of 4 medication carts. The facility was again recited for F 431 during the April 11, 2014 recertification and complaint survey for failure to discard an opened insulin medication vial that was expired for 4 days and was available for use in 1 of 4 medication carts. On the current recertification survey the facility was again recited for failure to securely store medications in 1 of 2 medication rooms. c. F 520 Quality Assessment and Assurance	F 520	proper return demonstration of pericare. B) F431: Implemented additional audit where the Director of Nursing or designee will monitor all medication storage areas once weekly for 3 consecutive months to ensure that medications are securely stored in locked compartments. 2. A) F312: Staff Development Coordinator immediately assessed all other incontinent residents for appropriate peri-care on 7/1/2015. No other issues with peri-care were identified. B) The consultant pharmacist immediately assessed all other medication storage areas in the facility. All other medications were securely and properly stored. 3. The facility Quality Assessment and Assurance Program (QAA) was re-assessed by the Administrator and Director of Nursing Services on 7/20/2015. The following revisions were made and approved by the Medical Director and QAA committee members: ¿ The committee will meet on a monthly basis versus quarterly. ¿ The QA agenda was revised to include the reporting of audit results based on observations as specified under Item # 4 for F312. ¿ The QA agenda was also revised to include the reporting of audit results based on monitoring as specified under item #4 for F431 ¿ The Administrator and Director of Nursing Services met with the Consultant Pharmacist on 7/2/2015 to review the	

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F 520	Continued From page 21 Committee: Based on observations, record reviews and staff and resident interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in May 2014. This was for one recited deficiency which was originally cited in February 2013 on a recertification survey, again on a recertification and complaint survey in April 2014 and again on the current recertification survey. The deficiency was in the area of medication labeling and storage. Two additional recited deficiencies were originally cited in April 2014 on a recertification and complaint survey and again on the current recertification and complaint survey. The deficiencies were in the areas of activities of daily living and Quality Assessment and Assurance Committee. The facility's continued failure to implement and maintain procedures from a Quality Assessment and Assurance Committee, during three federal surveys of record, show a pattern of the facility's inability to sustain an effective Quality Assurance Program. During the April 2014 recertification survey and complaint investigation, the facility was cited for failure to ensure there were no expired medications in 1 of 4 medication carts and for failure to provide oral care for residents who required extensive assistance for activities of daily living as part of the monitoring process for quality assurance. The facility was recited during the current recertification survey and complaint investigation for failure to implement and maintain an effective QA program regarding 3 repeat deficiencies in the areas of medication labeling and storage for 3 federal surveys of record and for 2 repeat deficiencies in the areas of activities	F 520	items/areas monitored during her monthly visits. The items monitored monthly by the Consulting Pharmacy did include medication storage areas. However, to provide increased monitoring in this area, the Director of Nursing or designee will also monitor all medication storage areas once weekly for at least 3 consecutive months as indicated in item #4 of F Tag 431. 4. Results of audits related to F Tag 312 and F Tag 431 outlined above will be reported to the Quality Assessment and Assurance Committee by the DON and/or designee on a monthly basis beginning with the next scheduled QA meeting in July 2015. The QA committee will continue to analyze trends/possible causal factors and act accordingly to resolve instances of non compliance.	

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F 520	Continued From page 22 of daily living, and QA during two federal surveys of record. During an interview on 07/02/15 at 5:42 PM with the facility Administrator, he confirmed the facility had a Quality Assessment and Assurance Program that met quarterly. He stated the committee had monitored the plans of correction for prior surveys. He further stated they had focused their efforts only on the specific issues that were cited previously and he was unaware of the current issues that were found during the current survey.	F 520		