STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345201	A. BUILDING _____ B. WING _____	C 07/16/2015

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GOLDEN LIVINGCENTER - CHARLOTTE	2616 EAST 5TH STREET CHARLOTTE, NC 28204

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F 157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on physician and staff interviews and record review the facility failed to notify the physician when as needed pain medication was	F 157	Preparation on and/ or execution of this plan of correction does not constitute admission or agreement by the provider of	8/13/15

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

Electronically Signed | 08/07/2015

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F 157	Continued From page 1 not effective for a resident in severe pain for 1 of 5 sampled residents (Resident #64). The findings included: Resident #64 was admitted to the facility on 03/03/11 with diagnoses that included history of cerebrovascular accident with right sided hemiparesis, aphasia and a fractured femur (12/25/14). The Minimum Data Set (MDS) prior to Resident #64's fractured femur was dated 10/31/14 and specified the resident had moderately impaired cognition and was on a pain medication regimen. Review of Resident #64's physician orders revealed the resident had the following pain medications prescribed: - Norco 1 tablet every 6 hours as needed for moderate generalized pain dated 02/25/14 - Norco 2 tablets every 6 hours as needed for severe generalized pain dated 02/25/14 Further review of Resident #64's medical record revealed nurses' entries made by Nurse #1. On 12/25/14 at 8:50 AM Nurse #1 documented that Resident #64 complained of bilateral leg pain and was given 1 tablet of Norco for moderate pain. Additional entries made by Nurse #1 were: - On 12/25/14 at 9:19 AM Resident #64 refused Restorative therapy services due to pain - On 12/25/14 at 9:21 AM Resident #64 complained of pain during morning care provided by nurse aide #1 - On 12/25/14 at 1:58 PM Resident #64's pain medication was ineffective After Nurse #1 documented that Resident #64's pain medication was ineffective, shift change occurred and Nurse #2 provided care for Resident #64. On 12/25/14 at 6:34 PM Nurse #2 gave Resident #64 2 Norco tablets for severe pain and documented the following: - On 12/25/14 at 6:34 PM Resident #64 was	F 157	the truth of facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law. This plan of correction is submitted as the facility's credible allegations of compliance. 1. Resident #64 has no current change in condition. In the event that his condition changes the physician will be notified timely. 2. Each resident has the potential to be affected by this deficient practice. 3. Nurses will be educated before 8/13/2015 by the DNS/designee to notify resident's physician/nurse pracitioner of a change of condition in a timely maner. There will be an audit of each resident's clinical chart for changes of condition, timeliness of notification to Medical Director before 8/13/2015. For those residents identified as having a change of condition the Medical Director/The on call physicican/Nurse Practitioner will be notified by the charge nurse/ unit manager/DNS. Audits will be conducted daily for one month then weekly for two months by the DNS/designee. 4. Findings of audits will be presented to the QAPI meetings by the DNS/designee monthly for 3 months then ongoing as needed to ensure compliance.	

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refusing to eat and get out of bed related to pain
- On 12/25/14 at 9:04 PM Resident #64's pain medication was ineffective
- On 12/25/14 at 11:43 PM Resident #64 "lying in bed all day complaining of pain and moaning and groaning. Pain medications given and not effective." Emergency Medical Services (EMS), physician and family were notified.

On 07/15/15 at 10:50 AM Nurse #1 was interviewed and reported that her usual process for managing a resident with pain was to determine the severity of the pain either by asking them using a 1 to 10 pain scale or for non-verbal residents looking at facial expressions. She explained that once medication was given she waited an hour to see if the medication was effective. If the medication was not effective, she would review the physician orders to determine if additional pain medicine was ordered and if not then she would contact the physician. Nurse #1 stated that if a resident presented with severe unexplained pain and appeared in distress then she would immediately contact the physician. Nurse #1 added that Resident #64 took scheduled pain medications that controlled his pain but on occasion required additional pain medication that was ordered for "as needed." Nurse #1 stated that was assigned to work 7 AM to 3 PM on 12/25/14 as Resident #64's nurse. Nurse #1 stated that on 12/25/14 Resident #64 started to complain of leg pain that morning and she gave him pain medication and couldn't recall if it was effective and could not describe the resident's pain. Nurse #1 reviewed Resident #64's medical record and the entries she made that specified Resident #64's pain medication was ineffective. The Nurse stated that she would have given more medication and called the physician if it was also ineffective. Nurse #1

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F 157	Continued From page 3 stated that she could not recall if she contacted the physician. Nurse #2 was no longer employed at the facility and was unable to be reached. On 07/16/15 at 3:30 PM the Director of Nursing (DON) was interviewed and stated that he would expect nurses to administered pain medication as needed, assess for effectiveness, re-administer medications if ordered and then contact the physician if the resident was still in pain. He stated that Nurse #1 should have contacted the physician prior to the end of her shift when she documented that the resident's pain medication was ineffective. On 07/16/15 at 2:40 PM the medical director was interviewed and stated that he would expect a nurse to contact the physician when an "as needed" pain medication was ineffective. He explained that a sudden onset of newly developed pain that was unexplained he would expect the nurse to contact the physician right then because the resident would need to be sent to the Emergency Department for evaluation.	F 157		
F 242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, staff	F 242	1. Dietary communication form was	8/13/15

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F 242	Continued From page 4 interviews, a physician's order and interview and review of facility records, the facility failed to honor food preferences for dairy products (Resident #115), dry cereal and yogurt (Resident #78) and a fruit plate (Resident #147) for 3 of 6 sampled residents reviewed for choices. The findings included: 1. Resident #115 was admitted to the facility 12/29/14. A physician's order dated 12/29/14 documented that Resident #115 was lactose intolerant and should not receive milk or cheese products. Additionally a physician's order dated 04/20/15 recorded "ok to have milk products." A quarterly minimum data set (MDS) dated 04/27/15 assessed Resident #115 with intermittent confusion. Resident #115 was observed on 07/15/15 at 09:11 AM eating breakfast in her room. A tray card which accompanied her breakfast meal recorded an allergy to dairy products. Resident #115 did not receive dairy products with her breakfast meal. Resident #115 stated that the allergy to dairy products should have been removed from her tray card. Resident #115 further stated that because her tray card recorded an allergy to dairy products, she did not receive dairy products unless she specifically requested it and she did not understand why she had to do that. Resident #115 stated she wanted to have dairy products or ice cream with her meals. She stated "I have told them that I am not allergic to dairy." During an interview on 07/16/2015 at 09:49 AM, the west wing unit manager (WWUM) stated that	F 242	written for resident #115 by Nurse Patricia Kelly on 07/16/15 to eliminate the milk allergy notification from the tray card. Resident #78 received yogurt and dry cereal by CDM during the survey on 7/16/15. Resident #147 received follow up by the CDM on 07/31/15 to ensure resident is receiving items as requested from the bistro menu or alternate menu. 2. Each resident with meals provided by dietary have the potential to be affected. 3. CDM/designee will provide education to current dietary staff before 8/13/15 regarding food preferences and the right to make choices, and also tray card accuracy. The CDM/designee will utilize a QI monitoring tool to conduct daily audites of tray card vs tray items. The audit will monitor a minimum of one meal per day X 12 weeks. 4. The CDM will report the results of the QI monitoring tools to the QAPI committee monthly X 3 months to identify any trends that require further education and/or monitoring as well as revisions required to sustain substantial compliance.	

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on admission the family of Resident #115 expressed that they thought Resident #115 had an allergic reaction to dairy products in the hospital. Therefore, a physician's order was written that Resident #115 was lactose intolerant. The WWUM stated Resident #115 began requesting dairy products and recently ate two bowls of ice cream with no reaction. After this the registered dietitian (RD), certified dietary manager (CDM) and medical director (MD) got involved and the MD wrote an order that it was ok for Resident #115 to have dairy products. The WWUM stated that the nurse who transcribed the physician's order should have written communication to the dietary department to remove the no dairy order. The WWUM further stated "this has been a big topic of discussion on a weekly basis" and has been discussed during care plan meetings because Resident #115 has expressed that she wants to have dairy products. The medical record for Resident #115 was reviewed during this interview and the WWUM confirmed that a dietary communication slip was not available.

During an interview on 07/16/15 at 10:03 AM, the CDM stated he was unaware of the MD order for Resident #115 allowing her to have dairy products and that he did not receive a dietary communication slip regarding this.

During a telephone interview on 07/16/2015 at 10:50 AM, nurse #3 stated she remembered transcribing a physician's order for Resident #115 that it was ok for her to have dairy products, but nurse #3 stated she could not recall completing a dietary communication slip regarding this physician's order. She stated that if she completed it, a copy would be in the resident's

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medical record and a copy would be with the dietary department.

During an interview on 07/16/2015 at 10:54 AM, the RD stated that she recalled a time when Resident #115 became very upset that she was not offered ice cream during an activity. The RD stated she explained to the Resident that this was because of her intolerance to lactose and offered to talk the MD regarding the Resident's request. The RD stated that the MD wrote a physician's order that it was ok to give Resident #115 milk products, but since the MD did not write a physician's order to discontinue the milk allergy, "I did not complete a dietary communication slip, we have just provided her with milk products when she asks for it." The RD further stated that she also did not clarify the order to determine if the milk allergy should have been removed from the medical record.

During an interview with the MD on 07/16/2015 at 3:02 PM, he stated that when he wrote the physician's order that it was ok for Resident #115 to have milk products he expected staff to remove the milk allergy from the medical record and provide dairy products at will.

b. Resident #78 was admitted to the facility on 06/23/12. An annual MDS dated 05/18/15 assessed Resident #78 with intact cognition.

Resident #78 was observed on 07/15/2015 at 09:15 AM with his breakfast meal with tray set up completed by nurse aide (NA) #4. The tray card which accompanied his meal recorded a preference for yogurt. Resident #78 did not receive yogurt with his breakfast meal. Resident #78 stated that he would like to have his yogurt,

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but that he did not always receive it as requested.

Resident #78 was observed on 07/16/2015 at 08:51 with his breakfast meal with tray set up completed by NA #2. The tray card which accompanied his meal recorded a preference for dry cereal. Resident #78 did not receive the dry cereal with his breakfast meal. NA #2 stated in interview during the observation that he set up the breakfast tray for Resident #78 but that he just looked at the name on the tray card to make sure the tray belonged to Resident #78. NA #2 stated that he expected the kitchen to send residents the foods that were on the tray card and for the resident to tell him if he wanted anything more. NA #2 stated that since Resident #78 was eating his breakfast, "I assumed he had everything he wanted, I did not have the time to look at everything on the tray card to make sure it was all there." Resident #78 stated that he wanted the dry cereal "if I can get it."

During an interview on 07/16/15 at 09:15 AM, the WWUM stated that it had been a repeated problem for residents to receive the foods they requested. The WWUM stated that nursing staff had to "go back and forth with the kitchen" to get the foods the residents wanted which were not included on the meal tray. The WWUM stated this took time away from assisting residents with their meals. The WWUM stated this concern had also been discussed during clinical start up meeting with the CDM present.

During an interview with the CDM on 07/16/15 at 09:24 AM, he stated that Resident #78 should have received the yogurt and the cereal as per the tray card.

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During an interview on 07/16/2015 at 9:40 AM, NA #4 stated that Resident #78 did not receive yogurt with his breakfast meal on 07/15/15 and that sometimes residents don't always get everything that's on their tray card; if the resident tells us they want something else, we go get it for them.

During an interview on 07/16/2015 at 5:24 PM, the administrator stated that she expected the dietary department to send residents their foods per the tray card and if the resident did not receive what was on their tray card, she expected the nursing staff to make sure the resident received all the foods listed on the tray card.

c. Resident #147 was admitted to the facility on 06/10/15. An admission MDS dated 06/18/15 assessed Resident #147 with intact cognition.

Review of food committee meeting minutes from 05/29/15 and 06/25/15 revealed residents voiced concerns that they did not always receive items requested from the "Bistro Menu". Documented follow up to this concern recorded that staff re-education was provided.

During an interview on 07/13/15 at 12:58 PM, Resident #147 expressed that "when you ask for something from the Bistro Menu, sometimes we have been told we can't have it, the cook will say it's not available, like yesterday (Sunday) I asked for a fruit plate and the cook said she was not going to fix it." Resident #147 stated he informed the CDM who addressed it with staff, "but when he is not here the cooks do what they want to do."

During an interview with the CDM on 07/15/15 at 5:30 PM, he stated that Resident #147 expressed

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F 242	Continued From page 9 that he requested a food item from the "Bistro Menu", but did not receive it. The CDM described the "Bistro Menu" as a menu of foods chosen by residents who attended the food committee meetings. The menu included a fruit plate. Residents requested to have specific foods be available with each meal in case the resident did not want the main entrée or the alternate entrée. The CDM stated that dietary staff were re-educated in May 2015 and June 2015 due to concerns expressed that they did not always receive foods from this menu when requested. The CDM also stated that he had not had a chance yet to observe the meal services on a weekend to ensure weekend dietary staff provided residents with foods from the "Bistro Menu" as requested. During an interview on 07/16/15 at 12:08 PM, the RD consultant stated that she was not aware that there were times that foods from the "Bistro Menu" were not available to residents on the weekends. The RD consultant stated that was not how the "Bistro Menu" was designed and she expected that residents would receive foods from this menu when requested. During an interview on 07/16/2015 at 5:24 PM, the administrator stated that she expected the dietary department to honor residents' food preferences.	F 242		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's	F 272		8/13/15

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F 272	Continued From page 10 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; 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 observation, resident and staff interview and record review, the facility failed to	F 272	1. The comprehensive assessment for resident #73 and #126 will be modified to	

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F 272	Continued From page 11 conduct a comprehensive assessment related to psychoactive medication and nutrition for 2 of 9 sampled residents to identify how condition affected each resident's function and quality of life (Residents #73 and #126). The findings included: 1. Resident #73 was admitted to the facility on 12/24/14 with diagnoses which included anoxic brain damage, anxiety, depression, and end stage renal disease. Review of Resident #73's monthly April 2015 physician's orders revealed medications included Seroquel (an anti-psychotic) 50 milligrams (mg.) twice daily, Trazodone (an anti-depressant) 50 mg. at bedtime, and Zoloft (an anti-depressant) 50 mg daily. Review of Resident #73's annual Minimum Data Set (MDS) dated 04/16/15 revealed an assessment of moderately impaired cognition with no behavior problems. The MDS indicated Resident #73 received anti-psychotic and anti-depressant medications. Review of Resident #73's Psychotropic Drug Use Care Area Assessment (CAA) dated 05/15/15 revealed there was no documentation of an analysis of the findings with a description of the problem, causes and contributing factors, and risk factors related to the care area. The CAA did not contain the name, dose or frequency of the psychoactive medications used by Resident #73. The CAA indicated Resident #73 exhibited adverse consequences of anxiety, falls, sedation, balance disturbance, and seizures with no documented description or analysis of these	F 272	accurately reflect the current status of the resident. 2. Each resident have the potential to be affected by this deficient practice. 3. Current care plan members will be re-educated on conducting a comprehensive assessment to include the CAA process by Clinical reimbursement specialist/desginee before 08/13/15. This training will be completed to ensure that comprehensive assessments will be completed to include the problem, causes and contributing factors and/or related risk factors and analysis of the findings. The care plan coordinators/designee will audit the comprehensive assessments completed the week prior as available to ensure the current status of the resident is reflected. This audit will occur weekly X 12 weeks. 4. The results of the audit will be forwarded to the QAPI committe on a monthly basis X 3 months.	

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adverse consequences. There was no documentation of an analysis of the findings supporting the decision to proceed or not to proceed to the care plan.

Interview with the MDS Coordinator on 07/16/15 at 2:04 PM revealed she was not aware an analysis of Resident #73's medication, behavior, presence of adverse consequences of medication, and resident or family input was required. The MDS Coordinator explained the software program worksheet automatically populated the section entitled analysis of findings so she thought it was complete.

2. Resident #126 was admitted to the facility on 02/13/15 with diagnoses which included congestive heart failure, iron deficiency anemia, and chronic pancreatitis.

Review of Resident #126's admission Minimum Data set (MDS) dated 02/20/15 revealed an assessment of moderately impaired cognition. The MDS indicated Resident #126 independently consumed meals after tray set up and received a therapeutic diet.

Review of Resident #126's Care Area Assessment (CAA) dated 02/20/15 revealed there was no documentation of an analysis of the findings with a description of the problem, causes and contributing factors, and risk factors related to the care area. The CAA analysis section indicated pain, anemia, poor memory and diuretic use. There was no documentation of the type and dose of diuretic, analysis of laboratory values, or type of anemia. The CAA indicated the presence of pain, but did not document the location, severity or frequency and impact upon

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F 272	Continued From page 13 nutritional status. Interview with the Registered Dietician (RD) on 07/16/15 at 2:18 PM revealed the software program worksheet automatically populated the section entitled analysis of findings. The RD explained she used a data collection form as the analysis. The RD reported she interviewed Resident #126 but did not document an analysis or description of Resident #126's pain, edema, anemia, poor memory and diuretic use.	F 272		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, staff, physician, transportation driver and dialysis nurse interviews and record review the facility failed to intervene when pain medication was ineffective for a resident in severe pain for 1 of 4 sampled residents (Resident #64) and the facility failed to maintain communication with an outside dialysis center for 1 of 2 sampled residents who receive dialysis care (Resident #73). The findings included: 1. Resident #64 was admitted to the facility on 03/03/11 with diagnoses that included history of cerebrovascular accident with right sided	F 309	1. Resident #64 currently has no acute onset of pain. His chronic pain is being treated with long acting pain medication along with as needed pain medication for treatment of breakthough pain. Resident #73 now has a dialysis communication book in place for daily correspondence with the dialysis center. 2. Each resident has the potential to be affected by this deficient practice. 3.The DNS or desginee will in-service licensed nursing staff on pain assessment and pain management, change of	8/13/15

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F 309	Continued From page 14 hemiparesis, aphasia and a fractured femur (12/25/14). The Minimum Data Set (MDS) prior to Resident #64's fractured femur was dated 10/31/14 and specified the resident had moderately impaired cognition, had no behaviors, required 2 person extensive assistance with bed mobility and transfers; walking did not occur and the resident was not steady with balance and only able to stabilize with staff assistance. The MDS also specified Resident #64 was on a pain medication regimen and occasionally had pain in the last 5 days. Resident #64 had a care plan to address pain discomfort initiated on 11/19/13 and updated quarterly but not dated that specified to administer pain medication as ordered and utilize pain monitoring tool to evaluate effectiveness of interventions. On 07/14/15 at 12:30 PM Resident #64 was observed in his wheelchair and showed no signs of pain that included pained facial expressions, verbalization of pain, strenuous breathing or body language that would suggest pain. Review of Resident #64's physician orders revealed the resident had the following pain medications prescribed: - Norco 1 tablet every 6 hours as needed for moderate generalized pain dated 02/25/14 - Norco 2 tablets every 6 hours as needed for severe generalized pain dated 02/25/14 Review of Resident #64's Medication Administration Record (MAR) revealed the resident received 2 doses of Norco 1 tablet for moderate pain that was ineffective on 12/05/14 and 12/25/14 and the resident received 2 doses of Norco 2 tablets for severe pain that was effective on 12/05/14 and 12/16/14 but received a dose of Norco 2 tablets for severe pain on 12/25/14 that was ineffective.	F 309	condition, and timeliness of notification to physician/nurse practioner before 08/13/15. There will be a pain assessment audit on each resident by the DNS or designee before 08/13/15. For residents identified as having pain, interventions will be implemented. Pain assessments will be completed upon admission, readmission, and changes of condition. DNS or designee will randomly audit 10 resident charts weekly for four weeks, then monthly for 2 months. The DNS/desginee will in-service licensed nursing staff on communication with dialysis as being essential for continuity of care before 08/13/15. A complete audit of dialysis communication books will be completed before 08/13/15. For those residents identified as not having proper communicatin books they will be implemented. DNS or designee will audit dialysis communication books daily Monday-Friday for four weeks then weekly for 2 months. 4. Findings of audits will be presented to the QAPI meetings by the DNS or designee monthly for 3 months then ongoing as needed to ensure compliance.	

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F 309	Continued From page 15 Further review of Resident #64's medical record revealed nurses' entries made by Nurse #1. On 12/25/14 at 8:50 AM Nurse #1 documented that Resident #64 complained of bilateral leg pain and was given 1 tablet of Norco for moderate pain. Additional entries made by Nurse #1 were: - On 12/25/14 at 9:19 AM Resident #64 refused Restorative therapy services due to pain - On 12/25/14 at 9:21 AM Resident #64 complained of pain during morning care provided by nurse aide #1 - On 12/25/14 at 1:58 PM Resident #64's pain medication was ineffective After Nurse #1 documented that Resident #64's pain medication was ineffective, shift change occurred and Nurse #2 provided care for Resident #64. On 12/25/14 at 6:34 PM Nurse #2 gave Resident #64 2 Norco tablets for severe pain and documented the following: - On 12/25/14 at 6:34 PM Resident #64 was refusing to eat and get out of bed related to pain - On 12/25/14 at 9:04 PM Resident #64's pain medication was ineffective - On 12/25/14 at 11:43 PM Resident #64 "lying in bed all day complaining of pain and moaning and groaning. Pain medications given and not effective." Emergency Medical Services (EMS), physician and family were notified. A documented titled "Hospital Discharge Summary" dated 12/27/14 specified Resident #64 was admitted to the hospital 12/25/14 and diagnosed with a fractured right femur. The document also specified Resident #64 right proximal femur fracture was the result of a fall on 12/25/14 at the nursing facility. The decision was made to proceed with non-operative management due to extensive history of comorbidities and that Resident #64 had been non-ambulatory prior to hospital admission.	F 309		

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On 07/15/15 at 10:50 AM Nurse #1 was interviewed and reported that her usual process for managing a resident with pain was to determine the severity of the pain either by asking them using a 1 to 10 pain scale or for non-verbal residents looking at facial expressions. She explained that once medication was given she waited an hour to see if the medication was effective. If the medication was not effective, she would review the physician orders to determine if additional pain medicine was ordered and if not then she would contact the physician. Nurse #1 stated that if a resident presented with severe unexplained pain and appeared in distress then she would immediately contact the physician. Nurse #1 reported that she was regularly assigned to care for Resident #64 and that due to the resident's aphasia (unable to speak) he was difficult to understand but made some verbalizations that she was able to understand. She added that she could tell when the Resident was in pain from facial expressions and some words. Nurse #1 added that Resident #64 took scheduled pain medications that controlled his pain but on occasion required additional pain medication that was ordered for "as needed." Nurse #1 stated that was assigned to work 7 AM to 3 PM on 12/25/14 as Resident #64's nurse. Nurse #1 stated that on 12/25/14 Resident #64 started to complain of leg pain that morning and she gave him pain medication and couldn't recall if it was effective. She added that when she returned to work on 12/26/15 she was notified that Resident #64 had fallen and had a fractured leg. Nurse #1 stated that she did not get report that Resident #64 fell on 12/25/14 while she was assigned to him. Nurse #1 was able to recall that nurse aide #1 was assigned to Resident #64 on 12/25/14 from 7 AM to 3 PM and never reported

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to her any incidents during the shift.
Nurse #1 reviewed Resident #64's medical record and the entries she made that specified Resident #64's pain medication was ineffective. The Nurse stated that she would have given more medication and called the physician if it was also ineffective. Nurse #1 stated that she could not recall if she contacted the physician. Nurse #1 also stated that she did not document that she assessed Resident #64's legs for the new complaint of bilateral leg pain. Nurse #1 was unable to recall any other details that occurred on 12/25/14.
Nurse aide #1 was no longer employed at the facility and unable to be reached for an interview.
Nurse #2 was no longer employed at the facility and unable to be reached for an interview.
On 07/15/15 at 12:50 PM the Director of Nursing (DON) was interviewed and reported that he was on vacation on 12/25/14 but received a phone call from the facility that Resident #64 was being sent to the Emergency Department. The DON stated that the former Administrator investigated Resident #64's fractured femur. The DON reported that he was told the results of the investigation revealed that on 12/25/14 nurse aide #1 attempted to transfer Resident #64 and the resident started to fall, nurse aide #1 "caught" him, returned the resident to the chair and never reported the incident to Nurse #1. Resident #64 started to complain of pain after morning care. The DON did not know if Resident #64 was lowered to the ground and he was unable to answer any other questions surrounding the circumstances of the incident. The DON did not know what level of assistance Resident #64 required for transfers on 12/25/14.
On 07/16/15 at 3:30 PM a second interview was conducted with the DON who reviewed Resident

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F 309	Continued From page 18 #64's medical record and nurses' entries that specified the resident complained of pain at 8:50 AM and was not given effective medication and the physician was not contacted when it was identified the pain medication was ineffective and the resident had a fractured femur. The DON stated that he would expect nurses to administered pain medication as needed, assess for effectiveness, re-administer medications if ordered and then contact the physician if the resident was still in pain. On 07/16/15 at 2:40 PM the medical director was interviewed and stated that he would expect a nurse to contact the physician when an "as needed" pain medication was ineffective. He explained that a sudden onset of newly developed pain that was unexplained he would expect the nurse to contact the physician right then because the resident would need to be sent to the Emergency Department for evaluation. 2. Review of the facility's dialysis guidelines revised 2013 revealed communication between the facility and dialysis center "is essential for continuity of care." The guideline specified communication should include: a "written communication form with review of daily weights, any changes in condition or mood, identification of the type of vascular access and issues with patency or signs of infection." Review of the facility's communication form revealed instructions for staff to complete the top portion of the form prior to resident's dialysis treatment and send with resident each treatment.	F 309		

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The form contained sections for vital sign measurements, fasting blood sugar measurement with insulin dosage, description of access site, and condition changes in the last 24 to 48 hours. The form contained a section for the dialysis unit to complete at end of the resident's treatment. This section included pre and post dialysis vital sign measurements and weights with any additional changes.

Resident #73 was admitted to the facility on 12/24/14 with diagnoses which included diabetes mellitus and end stage renal disease.

Review of Resident #73's annual Minimum Data Set (MDS) dated 04/16/15 revealed an assessment of moderately impaired cognition. The MDS indicated Resident #73 received dialysis treatment.

Review of Resident #73's care plan revealed Resident #73 received dialysis treatment three days a week. Interventions included an assessment before and after dialysis treatment.

Review of Resident #73's electronic Medication Administration Record (eMAR) revealed a finger stick blood sugar measurement of 506 at 8:00 AM on 07/15/15. Resident #73's finger stick blood sugars at 8:00 AM from 07/1/15 to 0/7/14/15 ranged from 135 to 500. Nurse #1 documented administration of 14 units of Novolog insulin (a medication used to lower blood sugar) with physician notification. There were no new orders and there was no documentation of a repeat finger stick blood sugar.

Observation on 07/15/15 at 9:46 AM revealed Resident #73 seated in a high back wheelchair in

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the hallway outside the main dining room. A transportation company driver gave Resident #73 a bag lunch.

Interview with the transportation company driver on 07/15/15 at 9:48 AM revealed he regularly transported Resident #73 to the dialysis center. The driver explained he always went to the kitchen to obtain a bag lunch for Resident #73 before leaving.

Observation on 07/15/15 at 9:50 AM revealed the transportation company driver transported Resident #73 to the van without paperwork and drove away from the facility.

Interview on 07/16/15 at 8:21 AM with the East Wing Unit Manager revealed the facility communicated with the dialysis center with each dialysis treatment. The East Wing Unit Manager reported the hall nurse completed and placed the dialysis form in the resident's dialysis binder. This binder accompanied the resident to dialysis. The East Wing Unit Manager could not provide written dialysis communication forms or a binder for Resident #73.

Interview with Nurse #1 on 07/16/15 at 9:11 AM revealed she did not complete the dialysis communication form for Resident #73. Nurse #1 explained she did not see Resident #73 leave for dialysis yesterday (07/15/15). Nurse #1 reported could not recall the last time Resident #73's dialysis communication binder had been used. Nurse #1 reported she should complete the form and list the high blood sugar but could not recall the last time she used the form. Nurse #1 reported she did not inform the dialysis center of the blood sugar reading of 506.

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F 309	Continued From page 21 A second interview with the East Wing Unit Manager on 07/16/15 at 9:11 AM revealed Resident #73's dialysis communication binder could not be located. The East Wing Unit Manager reported the binder was not in the facility, at the dialysis center or in the transportation company's van. Telephone interview on 07/16/15 at 10:02 AM with the dialysis nurse revealed the dialysis center contacted the facility by telephone with critical issues. The dialysis nurse reported the dialysis was not aware of Resident #73's blood sugar measurement of 506. The dialysis nurse reported Resident #73 did not come to the center with a binder but occasionally brought a form for the center to complete. Interview with the Director of Nursing (DON) on 07/16/15 at 10:17 AM revealed the facility nurse should complete an assessment with documentation on a communication form prior to each dialysis treatment in order to communicate with the dialysis center. The DON reported communication of a critical nature would be conducted by telephone or facsimile.	F 309		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		8/13/15

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F 323	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to safely transfer a resident that was lowered to the floor and sustained a leg fracture and failed to keep fall precautions in place for a resident with a history of falls for 2 of 4 sampled residents (Resident #64 and #78). The findings included: 1. Resident #64 was admitted to the facility on 03/03/11 with diagnoses that included history of cerebrovascular accident with right sided hemiparesis, aphasia and a fractured femur (12/25/14). The Minimum Data Set (MDS) prior to Resident #64's fractured femur dated 10/31/14 specified the resident had moderately impaired cognition, had no behaviors, required 2 person extensive assistance with bed mobility and transfers; walking did not occur and the resident was not steady with balance and only able to stabilize with staff assistance. The MDS also specified Resident #64 had not fallen. Resident #64 had a care plan to address the resident's risk for falls initiated on 11/19/13 and updated quarterly that specified "education given to staff regarding proper transfer technique for this resident." The care plan did not specify what the "proper transfer technique" for Resident #64 was. Resident #64's "Care Sheet" (an instruction sheet for nurse aides to use when caring for residents), not dated, specified Resident #64 required 2 person assistance with transfers. Review of Resident #64's medical record revealed nurses' entries made by Nurse #1. On 12/25/14 at 8:50 AM Nurse #1 documented that Resident #64 complained of bilateral leg pain and was given 1 tablet of Norco for moderate pain.	F 323	1. Resident #64 care card and care plan are up to date with the resident's transfer status. Resident #78 now has both fall mats in place. 2. Each resident has the potential to be affected by this deficient practice. 3. The DNS/designee will educate nursing staff on fall management and prevention, interventions, preventive measures, and following care plans with the use of the care cards before 08/13/15. The DNS/designee will complete a facility audit of high risk residents and verify that fall risk interventions are in place and transfer status is up to date in care plan and CNA care cards before 8/13/15. Daily audits will document reported incidents and those that are reviewed by the clinical team in clinical start up meetings each Monday-Friday X 12 weeks. 4. Findings of audits will be presented to the QAPI meetings by the DNS/designee monthly X 3 months and then ongoing to ensure compliance.	

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On 12/25/14 at 9:20 Nurse #1 documented that Resident #64 was unable to participate in Restorative therapy due to leg pain. On 12/25/14 at 1:58 PM Nurse #1 documented that Resident #64's pain medication was ineffective.
Further review of Resident #64's medical record revealed that on 12/25/14 at 11:43 PM Nurse #2 documented that the resident was "lying in bed all day complaining of pain and moaning and groaning. Pain medications given and not effective." Emergency Medical Services (EMS), physician and family were notified.
A documented titled "Hospital Discharge Summary" dated 12/27/14 specified Resident #64 was admitted to the hospital 12/25/14 and diagnosed with a fractured right femur. The document also specified Resident #64's right proximal femur fracture was the result of a fall on 12/25/14 at the nursing facility. The decision was made to proceed with non-operative management due to extensive history of comorbidities and that Resident #64 had been non-ambulatory prior to hospital admission.
On 07/15/15 at 10:50 AM Nurse #1 was interviewed and reported that she was Resident #64's nurse on 12/25/14 from 7 AM until 3 PM. She explained that after nurse aide (NA) #1 provided morning care Resident #64 complained of bilateral leg pain. She gave the resident "as needed" pain medication for moderate pain in his legs. Nurse #1 reported that NA #1 had provided morning care for Resident #64 and had not reported any incidents or falls to her on 12/25/14. Nurse #1 stated that she could not recall any other details of that day and added she would have documented in the medical record any incidents or assessments that occurred during her shift. Nurse #1 explained that she returned to work on 12/26/14 at 7 AM and was notified that

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Resident #64 was hospitalized due to fractured femur from a fall in the facility. Nurse #1 could not recall what level of assistance Resident #64 required on 12/25/14 for transfers.
Nurse aide #1 was no longer employed at the facility and unable to be reached for an interview.
Nurse #2 was no longer employed at the facility and unable to be reached for an interview.
Attempts were made to contact nurse aides that had cared for Resident #64 on or around 12/25/14 and they did not return messages.
On 07/15/15 at 12:50 PM the Director of Nursing (DON) was interviewed and reported that he was on vacation on 12/25/14 but received a phone call from the facility that Resident #64 was being sent to the Emergency Department. The DON stated that the former Administrator investigated Resident #64's fractured femur. The DON reported that he was told the results of the investigation revealed that on 12/25/14 nurse aide #1 attempted to transfer Resident #64 and the resident started to fall, nurse aide #1 "caught" him, returned the resident to the chair and never reported the incident to Nurse #1. Resident #64 started to complain of pain after morning care. The DON did not know if Resident #64 was lowered to the ground and he was unable to answer any other questions surrounding the circumstances of the incident. The DON did not know what level of assistance Resident #64 required for transfers on 12/25/14.
On 07/16/15 at 9:45 AM the MDS Coordinator was interviewed and stated she was not familiar with Resident #64 and his level of assistance. The MDS Coordinator reviewed Resident #64's MDS dated 10/31/14 and reported that he required 2 person extensive assistance with transfers and that nurse aides should use two persons when transferring him unless that

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changed. She explained that nurse aides used "care sheets" that were developed by the Unit Managers for instructions on how to care for residents.
On 07/16/15 at 12:20 PM the East Wing Unit Manager was interviewed and reported that he developed and updated "care sheets" daily and the sheets were given to nurse aides for instructions on residents' individualized needs. He stated that Resident #64 had always required 2 person assistance with transfers for safety because of the Resident's dependent state and hemiparesis. He stated that it was possible Resident #64 could stand but needed additional assistance due to his hemiparesis.
On 07/16/15 at 11:30 AM the former Administrator was interviewed on the telephone and reported that she was notified Resident #64 had been admitted to the hospital for a fractured femur. She stated that she immediately started an investigation to determine the cause of the fracture. She explained that she conducted interviews with every staff member that had cared for Resident #64 48 hours prior to 12/25/14. The former Administrator added that NA #1 reported that while providing morning care on 12/25/14 he attempted to transfer Resident #64 from the bed to wheelchair, the resident started to fall, the nurse aide lowered Resident #64 to the floor, assisted Resident #64 off the floor and placed the resident in the wheelchair. The former Administrator stated that NA #1 did not report the incident to the nurse. The former Administrator stated that to her knowledge Resident #64 was able to stand and pivot for transfers and that it was acceptable for NA #1 to attempt to transfer the resident alone. The former Administrator reported that she concluded from her investigation Resident #64's fractured femur was

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a result of the incident on 12/25/14 during morning care. She added that NA #1 was re-educated on reporting all incidents to the nurse immediately.

2. Resident #78 was admitted to the facility on 06/23/12. Diagnoses and medical conditions included subdural hemorrhage, anxiety, convulsions and a personal history of falls.

A physician's order dated 10/11/13 documented to place floor mats at each side of the bed while in bed and to check for placement each shift.

Medical record review and review of incident reports revealed Resident #78 fell in his room from his wheel chair on 01/13/15 and from his bed on 06/30/15. He was uninjured.

A care plan reviewed May 2015 and a nurse aide communication tool updated 07/16/15 recorded to keep floor mats at the bedside while the resident was in bed.

Resident #78 was observed in a low bed on 07/15/2015 at 08:51 AM and on 07/16/15 at 08:30 AM with a fall mat to the floor on the left side of the bed. A second fall mat was observed folded against the wall.

An interview with nurse aide (NA) #3 occurred on 07/16/15 at 8:55 AM. NA #3 stated that she used the NA communication tool to know how to care for the residents she was assigned. NA #3 stated that staff kept the bed for Resident #78 in it lowest position, a tabs alarm in place and fall mats to the floor on both sides of his bed,

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F 323	Continued From page 27 because Resident #78 made attempts to self transfer and may fall due to a history of falls. NA #3 confirmed that both fall mats should have been on the floor while Resident #78 was in bed, but had no explanation as to why both fall mats were not on the floor. During an interview on 07/16/15 at 09:15 AM, the west wing unit manager confirmed that Resident #78 was at risk for falls and nursing staff should place fall mats to both sides of his bed while he was in bed and check for placement each shift.	F 323		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the	F 334		8/13/15

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F 334	Continued From page 28 influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.	F 334		

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F 334	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review the facility failed to administer and/or obtain consent for influenza and pneumococcal immunizations for 3 of 3 residents admitted during the influenza season (Resident #79, #3 and #58). The findings included: 1. Resident #79 was admitted to the facility on 01/30/15. The Admission Minimum Data Set (MDS) dated 02/06/15 specified Resident #79's cognition was intact but she was not offered and had not received the influenza or pneumococcal immunizations. Review of Resident #79's medical record revealed a document titled "North Carolina Resident Immunization Consent or Refusal Form" dated 01/31/15 that specified Resident #79 consented to receive the influenza and pneumococcal immunizations. Review of Resident #79's medication administration record (MAR) for January 2015 and February 2015 revealed that Resident #79 had not received the requested immunizations. Further review of Resident #79's medical record revealed that she was not diagnosed with influenza or pneumonia. On 07/15/15 at 9:45 AM Resident #79 was interviewed and stated she couldn't remember if she received influenza or pneumococcal immunizations. On 07/15/15 at 12:45 PM the Director of Nursing	F 334	1.Consent was confirmed and resident #79 has received her pneumococcal vaccine. Consent and administration of influenza vaccine will take place during the flu season. Resident #3 has recieved a first dose of the pneumococcal vacine in the community. Consent and administration of the influenza vaccine will take place during the flu season. 2. Each resident has the potential to be affected by this deficient practice. 3. DNS/designee will educate licensed nurses on the responsibilty of the facility to ensure that each resident is offered a pneumococcal immunization and an influenza immuninization annually October 1 through March 31 each year before 8/13/15. A complete audit of flu/pneumonia immunizations will be completed for each resident before 8/13/15. Any missing consents will be obtained and the pneumococcal vaccine will be administered by the DNS/designee to those who have consented. As flu season commences and vaccinations have been delivered all consents will be obtained or confirmed and then the vaccine will be administered to those who have consented. DNS/designee will audit each new admission chart weekly for 4 weeks then monthly for 2 months to ensure completion of influenza/pneumococcal	

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F 334	Continued From page 30 (DON) was interviewed and explained that he was currently overseeing the facility's infection control program in the absence of a Staff Development Coordinator. He reported that all admissions during the influenza season (October 1 through March 31) were offered influenza immunizations and all new admissions throughout the year were offered pneumococcal immunizations during the admission process. He explained that it was the admitting nurse's responsibility to review immunization status, obtain consent and administer requested immunizations. The DON reported that he was unaware of concerns that immunizations were not being offered and/or administered to residents. On 07/16/15 at 2:25 PM the MDS Coordinator was interviewed and explained that she reviewed the admission consent forms, MARs and hospital records to determine if residents had received influenza and pneumococcal immunizations. She added that if the facility had not administered the immunizations and the resident had not refused them then she documented on the MDS "not offered." The MDS Coordinator reported that she had not realized new admissions were not being offered the immunizations and should have notified the Unit Managers. 2. Resident #3 was admitted to the facility on 01/30/15 with diagnoses that included asthma, Congestive Heart Failure and others. The Admission Minimum Data Set (MDS) dated 02/06/15 specified the resident's cognition was intact and that she was not offered and did not receive the influenza or pneumococcal immunizations. Review of Resident #3's medical record revealed	F 334	consent and administration. 4.Findings of audits will be presented to the QAPI meetings by the DNS or designee monthly for 3 months then ongoing as needed to ensure compliance.	

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a document titled "North Carolina Resident Immunization Consent or Refusal Form" for influenza and pneumococcal immunizations. Resident #3's consent form was blank.

Review of Resident #3's medication administration record (MAR) for January 2015 and February 2015 revealed that Resident #3 had not received immunizations.

Further review of Resident #3's medical record revealed that she was not diagnosed with influenza or pneumonia.

On 07/16/15 at 10:35 AM Resident #3 was interviewed and reported that she was not asked on admission if she would like to have an influenza or pneumococcal immunization.

On 07/15/15 at 12:45 PM the Director of Nursing (DON) was interviewed and explained that he was currently overseeing the facility's infection control program in the absence of a Staff Development Coordinator. He reported that all admissions during the influenza season (October 1 through March 31) were offered influenza immunizations and all new admissions throughout the year were offered pneumococcal immunizations during the admission process. He explained that it was the admitting nurse's responsibility to review immunization status, obtain consent and administer requested immunizations. The DON reported that he was unaware of concerns that immunizations were not being offered and/or administered to residents.

On 07/16/15 at 2:25 PM the MDS Coordinator was interviewed and explained that she reviewed the admission consent forms, MARs and hospital

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records to determine if residents had received influenza and pneumococcal immunizations. She added that if the facility had not administered the immunizations and the resident had not refused them then she documented on the MDS "not offered." The MDS Coordinator reported that she had not realized new admissions were not being offered the immunizations and should have notified the Unit Managers.

3. Resident #58 was admitted to the facility on 01/28/15 and discharged home on 02/27/15 with diagnoses that included asthma and bronchitis. The Admission Minimum Data Set (MDS) dated 02/04/15 specified the resident's cognition was intact and that she was not offered and did not receive the influenza or pneumococcal immunizations.

Review of Resident #58's medical record revealed a document titled "North Carolina Resident Immunization Consent or Refusal Form" for influenza and pneumococcal immunizations. Resident #58's consent form dated 02/09/15 was left blank.

Review of Resident #58's medication administration record (MAR) for January 2015 and February 2015 revealed that Resident #58 had not received immunizations.

Further review of Resident #58's medical record revealed that she was not diagnosed with influenza or pneumonia.

On 07/15/15 at 12:45 PM the Director of Nursing (DON) was interviewed and explained that he was currently overseeing the facility's infection control program in the absence of a Staff

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F 334	Continued From page 33 Development Coordinator. He reported that all admissions during the influenza season (October 1 through March 31) were offered influenza immunizations and all new admissions throughout the year were offered pneumococcal immunizations during the admission process. He explained that it was the admitting nurse's responsibility to review immunization status, obtain consent and administer requested immunizations. The DON reported that he was unaware of concerns that immunizations were not being offered and/or administered to residents. On 07/16/15 at 2:25 PM the MDS Coordinator was interviewed and explained that she reviewed the admission consent forms, MARs and hospital records to determine if residents had received influenza and pneumococcal immunizations. She added that if the facility had not administered the immunizations and the resident had not refused them then she documented on the MDS "not offered." The MDS Coordinator reported that she had not realized new admissions were not being offered the immunizations and should have notified the Unit Managers.	F 334		
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by:	F 363		8/13/15

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F 363	Continued From page 34 Based on observations, staff interviews and review of facility records, the facility failed to prepare a 4 ounce portion of sliced bananas for 19 residents on a mechanical soft diet (Residents #28, #27, #16, #72, #42, #9, #2, #38, #79, #119, #41, #64, #46, #73, #26, #55, #95, #17, #122) and prepare a 4 ounce portion of reduced fat milk for 17 residents on a consistent carbohydrate diet according to the menu (Residents #120, #3, #5, #119, #25, #21, #34, #82, #85, #83, #62, #99, #51, #49, #60, #131). The findings included: 1 a. Review of the 07/15/15 lunch menu revealed residents on a mechanical soft diet were to receive a 4 ounce portion of sliced bananas. A continuous observation of the lunch meal tray line occurred on 07/15/15 from 11:57 AM to 12:49 PM. During the observation bowls of sliced bananas was observed available on the lunch meal tray line stored in 5 ounce bowls. The bowls of sliced bananas were observed less then half full. The bowls of sliced bananas were placed on the lunch meal trays for residents and placed on the delivery cart. Dietary staff #2 stated in interview on 07/15/15 at 12:21 PM that the sliced bananas were for residents who received a physician prescribed mechanical soft diet. Dietary staff #2 stated she had 7 bananas available for 19 residents and this was not enough; she stated that she informed the certified dietary manager (CDM). Dietary staff #2 stated the CDM instructed her to "to stretch it". On 07/15/15 at 12:24 PM, per request of the surveyor, the CDM measured the amount of sliced banana available for the lunch meal and	F 363	1. The CDM has provided the appropriate measuring device for preparing servings. The CDM has also purchased 4 ounce cups to ensure appropriate servings of milk are given. 2. Each resident with meals provided by dietary have the potential to be affected. 3. The CDM/designee will provide education to current dieatry staff before 8/13/15 regarding portion control, menus and recipes. The CDM will utilize a QI monitoring tool to conduct daily audits to ensure correct food portions are served. This audit will monitor a minimum of one meal per day X 12 weeks. 4. The CDM will report the results of the QI monitoring tools to the QAPI committe monthly X 3 months to identify any trends that require further education and /or monitoring as well as revisions required to sustain susbtantial compliance.	

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measured approximately a 2 ounce portion of sliced bananas. The CDM stated he was not aware that the bananas were not sufficient to provide 19 residents (Residents #28, #27, #16, #72, #42, #9, #2, #38, #79, #119, #41, #64, #46, #73, #26, #55, #95, #17, #122) with a physician prescribed mechanical soft diet a 4 ounce portion of sliced bananas as per the menu.

A follow up interview with the CDM on 07/15/15 at 1:31 PM revealed that there were 19 residents with a physican prescribed mechanical soft diet order and these residents should have received a 4 ounce portion of sliced bananas per the menu. He further stated that he completed quality checks of the lunch meal tray line before the tray line started and during the tray line, but that he missed identifying the incorrect portion of sliced bananas available for residents who received a mechanical soft diet.

b. Review of the 07/15/15 lunch menu revealed residents with a physician prescribed consistent carbohydrate diet were to receive a 4 ounce portion of reduced fat milk.

A continuous observation of the lunch meal tray line occurred on 07/15/2015 from 11:57 AM to 12:49 PM. During the observation on 07/15/15 at 12:38 PM, dietary staff #1 was observed to pour reduced fat milk into 8 ounce cups. The cups of milk were placed on the lunch meal tray for residents. Dietary staff #1 stated the milk was for residents with a physician prescribed consistent carbohydrate diet. Dietary staff #1 did not measure the amount of milk she poured. On 07/15/15 at 12:41 PM dietary staff #1 confirmed that the meal cart was ready for delivery to residents. Per request of the surveyor, CDM

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measured the amount of milk poured into cups by dietary staff #1. The amount of milk measured approximately 3 ounces. The CDM instructed dietary staff #1 to measure the amount of milk poured and to provide residents with a 4 ounce portion of milk. Dietary staff #1 stated in interview on 07/15/15 at 12:42 PM that she did not measure the amount of milk she poured, but rather stated "I just poured it."

The CDM stated in an interview on 07/15/15 at 1:31 PM that there were 17 residents who received a physician prescribed consistent carbohydrate diet and according to the menu should have received a 4 ounce portion of reduced fat milk. The CDM further stated that he expected dietary staff #1 to use a measuring utensil when pouring milk to ensure residents received 4 ounces of milk. The CDM stated that he completed quality checks of the lunch meal tray line before the tray line started and during the tray line, but that he missed identifying the incorrect portions of reduced fat milk available for residents who received a consistent carbohydrate diet.

An interview was conducted with the registered dietitian (RD) consultant on 07/16/2015 at 12:15 PM. The interview revealed that she visited the facility weekly to conduct sanitation audits, review medical records and talk to residents to see how they like the food. The RD consultant stated that she identfied concerns with portion control during past sanitation audits and discussed these concerns with the CDM. The RD consultant stated that she expected residents to receive food portions (bananas and milk) as per the menu.

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F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on 4 residents who attended food committee meetings (#33, #102, #36, #132), 7 resident interviews (147, 87, 145, 100, 70, 86 and 115), an observation of the lunch meal tray line, a test tray observation, and review of facility records, the facility failed to provide residents with foods based on their preferences for temperature and taste. The lunch meal tray line included fat free milk available at 49 degrees and reduced fat milk available at 60 degrees. A lunch meal test tray was observed with softened butter that did not melt on potatoes and congealed gravy served atop steak. The findings included: 1 a. Review of food committee meeting minutes revealed the following concerns with food temperature and taste: · 2/19/15 meeting - Residents #33 and #102 complained that pork chops were too tough, expressed they did not like the crust on desserts, requested more gravy on steak, chicken was over-cooked and that foods were too salty. · 6/25/15 meeting - Residents #36 and #132 complained that breakfast was cold, vegetables were under cooked, grits were too salty and diced	F 364	1. The CDM/designee will conduct a food preference update on each resident before 8/13/15. The CDM/designee will update tray cards to reflect the new food preferences by 8/13/15. The plate warmer was plugged in on 7/15/2015 to keep plates warm by the CDM and the Director of Maintenance. Skim milk and reduced fat milk with temperatures greater than 41 degrees F were discarded. The test tray was not served to any residents. 2. Each resident with meals provided by dietary have the potential to be affected. 3. The CDM will provide education to current dietary staff before 8/13/15 regarding the use of the plate warmer, and the pellet system. The CDM/designee will utilize a QI tool to document changes in preferences weekly X 12 weeks. 4. The CDM will report the results of the QI monitoring tools to the QAPI committee monthly X 3 months to identify any trends that require further education and/ or monitoring as well as revisions required to sustain substantial compliance.	8/13/15

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and baked potatoes were too hard.

During an interview on 07/15/15 at 5:19 PM, the certified dietary manager (CDM) stated that he addressed these concerns by in-servicing staff and advising residents that grits were cooked without the addition of salt. The CDM stated that he encouraged residents who expressed that the breakfast meal was cold to come to the main dining room for their meals.

During an interview on 07/16/2015 at 5:24 PM, the administrator stated she expected the dietary department to serve residents according to their meal preferences. The administrator further stated that the registered dietitian (RD) consultant left a report after each visit which required the CDM to complete a plan of correction for any concerns found. The administrator stated that the CDM was made aware that he was responsible to keep resident food preferences up-to-date and conducted daily resident rounds to do so. The administrator stated she was aware of some resident concerns related to food complaints from the grievance logs, but she was not aware of group resident concerns from food committee meetings.

b. An admission minimum data set (MDS) dated 06/18/15 assessed Resident #147 with intact cognition and independent with eating after tray set up.

During an interview on 07/13/15 at 12:58 PM, Resident #147 stated he has had to send his eggs back to the kitchen to be redone on the weekends because his eggs were too runny. He stated that he reported his concerns to the certified dietary manager (CDM) and his concerns

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were addressed, but when the CDM is not here on the weekends, the cooks do what they want to do.

c. An admission MDS dated 05/04/15 assessed Resident #87 with intact cognition and required supervision and staff assistance with meals.

During an interview on 07/13/15 at 12:59 PM, Resident #87 stated in April/May 2015 her food was received too salty and fruit was served in sugar water. Resident #87 stated she reported this to staff and some food has gotten better, but the fruit is still served in sugar water.

d. A nursing admission assessment dated 07/06/15 assessed Resident #145 with intact cognition and able to feed herself independently.

During an interview on 07/13/15 at 2:58 PM, Resident #145 stated that the food had flat flavor and was cooked without seasoning and "they cook it too death". Resident #145 stated the mashed potatoes she received on 07/12/15 had no flavor at all.

e. An admission minimum data set (MDS) dated 03/25/15 assessed Resident #100 with intact cognition and independent with eating, requiring set up help only.

During an interview on 07/13/15 at 3:46 PM Resident #100 stated the food was not seasoned well. Resident #100 stated she reported this to the CDM and some foods were better.

f. A quarterly MDS dated 06/09/15 assessed Resident #70 with intact cognition, independent with eating and tray set-up.

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During an interview on 07/14/15 at 9:59 AM Resident #70 stated grits were served cold, eggs were not good, the lunch meal was served cold, pork chops were too hard, BBQ sauce was too greasy and vegetables were not cooked, but sometimes served still frozen.

g. A quarterly MDS dated 05/12/15 assessed Resident #86 with intact cognition, requiring supervision with meals after tray set-up.

During an interview on 07/14/15 at 11:21 AM, Resident #86 stated that the food was not appetizing, she did not like salt in her foods, and the pork chops were too salty; since she reported her concerns to the CDM, some things were better, but the pork chops were still too salty.

h. A quarterly MDS dated 04/27/15 assessed Resident #115 with intermittent confusion and required extensive staff assistance of one person with meals.

During an interview on 07/14/15 at 11:55 AM, Resident #115 stated the food had no taste and she received baked chicken that was still raw inside about 1 - 2 months ago. Resident #115 stated that since she reported her concerns to the CDM, breakfast was better, lunch and supper still were not good and desserts were horrible.

g. A continuous observation of the lunch meal tray line occurred on 07/15/2015 from 11:57 AM until 12:49 PM and a test tray observation revealed the following concerns with food palatability:

· The lowerator (plate warmer) was not

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plugged in and was not in use during the continuous lunch meal tray line observation. During an interview on 07/15/15 at 12:44 PM, cook #1 stated that she did not use the lowerator to keep plates warm, she was not sure if it worked and stated "I'm scared to plug it in."

During an interview on 07/15/15 at 1:31 PM, the CDM stated that the lowerator worked and should be used to keep plates warm, but during his quality control walk thru before the tray line began, he did not see that the lowerator was not plugged in. Once plugged in, the lowerator was observed to work and the temperature dial was set to it lowest temperature setting.

· Approximately 15 individual cartons of skim milk were observed stored in a metal pan with a mixture of water and ice. Temperature monitoring revealed the skim milk was stored out of refrigeration at 49 degrees Fahrenheit (F). Approximately 12 cups of reduced fat milk, each covered with plastic film, was observed stored on a brown tray. Temperature monitoring revealed the reduced fat milk was stored out of refrigeration at 60 degrees F. During an interview on 07/15/15 at 1:31 PM, the CDM stated that he conducted a quality check of the lunch meal tray line before it began, but did not identify that milk was stored on the tray line out of refrigeration above 41 degrees F.

· A test tray for a regular diet was requested for the lunch meal on 07/15/15 at 12:46 PM. The meal included country fried steak with gravy, baked potato half, mixed vegetables, tropical fruit, water, tea and reduced fat milk. The meal tray arrived on the 200 hall at 12:51 PM. The test tray was set up by the CDM at 1:05 PM with the addition of salt, pepper and butter. Butter was observed soft but remained congealed when

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F 364	Continued From page 42 added to the baked potato half. The baked potato half and the mixed vegetables were observed without steam. The gravy was observed congealed on the steak. The mixed vegetables were observed with a dull color and mushy texture. The CDM tasted the lunch meal and stated that the baked potato half was "luke warm" and the steak was "warm, not hot, not piping hot". The RD consultant was interviewed on 07/16/15 at 12:15 PM and stated that she visited the facility weekly to conduct sanitation audits, review medical records and talk to residents to see how they like the food. The RD consultant stated she did not talk to residents about their food during last week's visit, she did not review minutes from food committee meetings and she was not informed of any resident concerns from food committee meetings. The RD consultant stated that she had worked with the CDM on food palatability in the past, but not recently.	F 364		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by:	F 371		8/13/15

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F 371	Continued From page 43 Based on observations, staff interviews and review of facility records the facility failed to 1) store potentially hazardous foods (bananas, potatoes, and onions) at least 45 degrees Fahrenheit or below according to manufacturer instructions, 2) maintain potentially hazardous foods (bananas and milk) at least 41 degrees or below on the lunch meal tray line, 3) serve a potentially hazardous food (milk) from the lunch meal tray line at least 41 degrees or below to 2 residents (Residents #79 and #83) and 4) remove dented cans from food items stored ready for for 2 of 2 tray line observations. The findings included: 1 a. An observation occurred on 07/13/2015 at 10:14 AM of dry storage and revealed items stored ready for use on a storage rack with large dents in the rims of each can to include: · 3 cans of ripe olives, 10 pounds each · 1 can spaghetti sauce, 10 pounds During an interview on 07/13/15 at 10:20 AM, the certified dietary manager (CDM) stated that the facility received food deliveries each Tuesday and Friday and he expected dietary staff to monitor dry storage for improperly stored items at that time. The CDM further stated that dented cans should be stored separately from ready to use foods. During an interview on 07/15/15 at 2:20 PM, dietary aide (DA) #3 stated that he was responsible to put stock away. DA #3 stated that dented cans should be stored separately from the cans used to serve residents. DA #3 stated that he did not notice the dents in the cans of olives or spaghetti sauce when he stored these items on	F 371	1. Dented cans located in the dry storage area were relocated to designated areas for dented cans by the CDM during the survey process. Produce stored outside of refrigeration were discarded by the CDM during the survey process. Skim milk, reduced fat milk, and bananas identified on the tray line were discarded during the survey process. 2. Each resident with meals provided by dietary have the potential to be affected. 3. The CDM will provide education to current dietary staff before 8/13/2015 regarding proper food storage, identifying dented cans and the appropriate location for dented cans. The CDM/designee will utilize a QI monitoring tool to conduct daily audits of food temperatures of at least one meal per day X 12 weeks. The CDM/designee will utilize a QI monitoring tool to conduct daily audits to assure that the dented cans are stored in the designated area at least one time daily X 12 weeks. 4. The CDM will report the results of the QI monitoring tools to the QAPI committee monthly X 3 months to identify any trends that require further education and/ or monitoring as well as revisions required to sustain substantial compliance.	

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the storage rack.

b. Review of manufacturer instructions recorded on the exterior containers of produce revealed instructions to store 45 degrees or below.

An observation on 07/15/15 at 2:15 PM revealed fresh produce stored outside refrigeration on the 2 lower shelves of prep tables to include:
- A 10 pound bag of onions
- 2 cases of red new potatoes
- 1 case of white potatoes
- 1 case of sweet potatoes

During an interview on 07/15/15 at 2:19 PM, DA #2 stated "this is where we store the onions, potatoes and bananas all the time."

During an interview on 07/15/15 at 2:20 PM, DA #3 stated that he was responsible to put stock away and that he always stored the potatoes, onions and bananas on the lower shelves of the prep tables.

During an interview on 07/15/15 at 2:25 PM, the CDM stated that "we do not refrigerate potatoes, onions or bananas", but rather has instructed his staff to store these foods on the lower shelves of the prep tables. The CDM stated he was not aware that all produce required refrigeration.

During an interview on 07/16/2015 at 10:39 AM the maintenance director stated he tested the ambient room temperature of the kitchen and obtained temperatures of 56 degrees Fahrenheit (F) and 61 degrees F coming directly from the vents. The maintenance director further stated that all produce should be refrigerated, especially

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during the summer months to prevent the attraction of pest activity.

During an interview on 07/16/15 at 12:15 PM, the RD consultant stated that she conducted weekly sanitation audits and had observed produce which included potatoes, onions and bananas stored outside refrigeration in the past. The RD consultant confirmed that if produce was not refrigerated this could be a source of pest activity.

2. The facility's policy "Holding and Serving", undated, recorded in part to hold potentially hazardous cold foods at a continuous temperature of 41 degrees Fahrenheit or below and not to hold potentially hazardous foods at room temperature during the meal service.

A continuous observation of the lunch meal tray line occurred on 07/15/2015 from 11:57 AM until 12:49 PM. The following concerns were observed with cold foods stored on the lunch meal tray line above 41 degrees F:
Approximately 15 cartons of skim milk, 8 ounces each, were observed stored in a metal pan with a mixture of water and ice. This milk was placed on residents' lunch meal trays for delivery. Temperature monitoring revealed the skim milk was stored at 49 degrees F.
Approximately 12 cups with 4 ounces of reduced fat milk, each covered with plastic film, was observed stored on a brown tray. This milk was placed on residents' lunch meal trays for delivery. Temperature monitoring revealed the reduced fat milk was stored at 60 degrees F.
Approximately 19 bowls of sliced bananas were observed available on the lunch meal tray line stored in 5 ounce bowls on a brown tray. The

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bowls of sliced bananas were placed on the lunch meal trays for residents and placed on the delivery cart. DA #2 stated in interview on 07/15/15 at 12:21 PM that the bananas were not refrigerated, but stored on the lower shelf of the prep table. DA #2 stated she sliced the bananas about 10 minutes just prior to the start of the lunch meal tray line, but did not refrigerate the bananas. DA #2 stated the sliced bananas were for residents who received a physician prescribed mechanical soft diet. Temperature monitoring revealed the bowls of sliced bananas were 70 degrees F.

During an interview on 07/15/15 at 12:41 PM, DA #1 stated the lunch meal cart was ready for delivery to residents. DA #1 stated she removed the milk from refrigeration around 11:30 AM, just before the start of the tray line. Temperature monitoring of the milk placed on the meal trays for Resident #79 and Resident #83 resulted in a temperature of 50 degrees F. The CDM instructed dietary staff to discard the milk and the bananas and serve milk and fresh fruit at least 41 degrees or below.

During an interview on 07/16/2015 at 12:15 PM, the RD consultant stated that she conducted weekly sanitation audits and left a report with the CDM to develop a plan of correction for any concerns found. The RD consultant further stated that during her sanitation audits, she found concerns with food temperatures and if this concern was noted during her visits, it is corrected at the time identified. The RD consultant stated she expected the CDM to monitor tray line temperatures and to serve milk and fresh fruit at least 41 degrees F or below.

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F 371	Continued From page 47 During an interview on 07/15/15 at 1:31 PM, the CDM stated that he conducted a quality check of the lunch meal tray line before it began, but did not identify that milk or the bananas were stored on the tray line out of refrigeration above 41 degrees F.	F 371		
F 469 SS=D	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and review of facility records, the facility failed to maintain a pest free kitchen. Fruit fly activity was noted during 2 of 2 kitchen observations. The findings included: Review of pest service reports revealed the facility received pest control services in January 2015 and April 2015 in the kitchen for fruit fly activity. On 07/13/15 from 9:45 AM thru 10:15 AM multiple fruit flies were observed in the kitchen. An observation on 07/15/15 at 2:15 PM in the kitchen revealed fruit fly activity in fresh produce which was stored outside refrigeration on the 2 lower shelves of prep tables to include: · A 10 pound bag of onions	F 469	1. Produce stored outside of refrigeration was discarded on 7/15/15. Pest service contractor arrived to facility on 7/17/15 to treat fruit fly activity in the kitchen. 2. Each resident with meals provided by dietary have the potential to be affected. 3. The CDM/designee will provide education to current dietary staff before 8/13/15 regarding proper food storage, and pest activity. The CDM/designee will utilize a QI monitoring tool to document daily monitoring of proper storage of produce X 12 weeks. This monitoring tool will also be used daily to document any observatins of fruit fly acitivity in the kitchen X 12 weeks. 4. The CDM/designee will report the results of the QI monitoring tools to the QAPI committee monthly X 3 months to identify any trends that require further	8/13/15

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F 469	Continued From page 48 · 2 cases of red new potatoes · 1 case of white potatoes · 1 case of sweet potatoes Review of manufacturer instructions revealed guidance to store produce at 45 degrees Fahrenheit or below. During an interview on 07/15/15 at 2:19 PM, dietary aide (DA) #2 stated "this is where we store the onions, potatoes and bananas all the time." DA #2 further stated that she had not noticed fruit flies recently. During an interview on 07/15/15 at 2:20 PM, DA #3 stated that he was responsible to put stock away and that he always stored the potatoes, onions and bananas on the lower shelves of the prep tables. DA #3 further stated that he noticed fruit fly activity in the recent past, but an exterminator came and sprayed, "but I guess they (fruit flies) have come back." During an interview on 07/15/15 at 2:25 PM, and review of a food delivery invoice dated 06/30/15, the certified dietary manager (CDM) stated potatoes, onions and bananas were not kept in refrigeration, but rather stored on the lower shelves of prep tables. The CDM stated he was aware that the kitchen had a previous concern with fruit fly activity and he monitored for this, but that he had not noticed any recent concerns. He provided an invoice which documented receipt of fresh produce on 06/30/15. During an interview on 07/16/2015 at 10:39 AM the maintenance director stated he tested the ambient room temperature of the kitchen and obtained temperatures of 56	F 469	education and / or monitoring as well as revisions required to sustain substantial compliance.	

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degrees Fahrenheit and 61 degrees Fahrenheit coming directly from the vents. The maintenance director further stated that all produce should be refrigerated, especially during the summer months to prevent the attraction of pest activity. The maintenance director stated that if fresh produce was left out and not refrigerated, this could attract fruit flies.

During a telephone interview on 07/16/2015 at 12:12 PM, a pest service contractor stated that he serviced the dietary department months ago for fruit fly activity, but had not received a recent request to treat for fruit flies. The interview revealed that fruit flies had a 10 day life span and could reproduce in less than a 24 hour period. He stated that fresh produce left out of refrigeration could provide a source for recurrent fruit fly activity.