STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345026	A. BUILDING ______ B. WING ______	C 10/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS	2700 ROYAL COMMONS LANE MATTHEWS, NC 28105

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F 159 SS=B	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the	F 159		10/26/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 10/26/2015

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F 159	Continued From page 1 SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, and record review, the facility failed to provide access to resident personal funds during the weekend for 2 of 21 sampled residents (Resident #66 and #134). The findings included: 1. Resident #66's comprehensive Minimum Data Set dated 8/31/2015 indicated she was cognitively intact. During an interview on 9/29/2015 at 8:37 AM, Resident #66 stated she had a resident trust account with the facility but did not have access to it on the weekend. Resident #66 indicated she had tried to get money but the business office manager did not work on the weekend and she said, "They are not down there on Saturday or Sunday." On 9/30/2015 at 3:11 PM, the Business Office Manager stated the Business Office, "regular hours are Monday through Friday." She added that most residents came to get money on Friday afternoon because on the weekend the receptionist could make change, but other than that she and her assistant were the only ones with access to the funds and residents would	F 159	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility¿s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 159 Corrective Action for Resident Affected; On October 2, 2015, the administrator explained to resident #66 and resident #134 how to access funds on the weekends. Resident funds will be available on weekends (Saturdays and Sundays) via the receptionist. Corrective Action for Resident Potentially Affected; All residents who have personal funds have the potential to be affected by this	

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F 159	Continued From page 2	F 159		

have to wait until Monday to access their accounts. The Business Office Manager indicated she was not aware of the requirement that residents should have access to petty cash on an ongoing basis.

The Administrator was interviewed on 9/30/2015 at 4:27 PM. The Administrator said if a resident wanted to access money over the weekend the resident should go the manager on duty and then the manager on duty would contact the administrator who would make certain the funds could be accessed. Since he had now become aware that this was an issue, he planned to run through the Quality Assurance Committee. The Administrator said, "I know how to put in place a system so residents would have access to their funds on weekends."

2. Resident #134's quarterly Minimum Data Set dated 6/17/2015 indicated he was cognitively intact.

During an interview on 9/29/2015 at 9:45 AM, Resident #134 stated he had a resident trust account with the facility but could not access his money on the weekend. Resident #134 said he had tried but the business office was not open on Saturdays.

On 9/30/2015 at 3:11 PM, the Business Office Manager stated the Business Office, "regular hours are Monday through Friday." She added that most residents came to get money on Friday afternoon because on the weekend the receptionist could make change, but other than that she and her assistant were the only ones with access to the funds and residents would have to wait until Monday to access their

practice. On October 2, 2015, the Business Office Manager & Recreation Director explained to the residents how they can access funds on the weekend.

Systemic Changes;

On October 2, 2015, the administrator inserviced all staff regarding the availability of resident personal funds for the weekends. Topics included: The receptionist on the weekends will have available funds for each resident that have funds available up to $5.00. The Business Office Manager utilizes a lock box that is passed to the receptionist for weekend funds availability. The BOM creates a list for that lock box indicating the resident names and if monies are available (up to $5.00) for each resident. If a resident requests funds from the receptionist, a signature sheet/receipt will track that resident withdrawal and will be signed by both the resident and the receptionist. The BOM will complete a reconciliation of all funds each Monday morning to ensure complete accountability and will then be verified by the Administrator.

This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.

Monitoring / Quality Assurance;

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F 159	Continued From page 3 accounts. The Business Office Manager indicated she was not aware of the requirement that residents should have access to petty cash on an ongoing basis. The Administrator was interviewed on 9/30/2015 at 4:27 PM. The Administrator said if a resident wanted to access money over the weekend the resident should go the manager on duty and then the manager on duty would contact the administrator who would make certain the funds could be accessed. Since he had now become aware that this was an issue, he planned to run through the Quality Assurance Committee. The Administrator said, "I know how to put in place a system so residents would have access to their funds on weekends."	F 159	To ensure compliance, the Business Office Manager will monitor this issue using the QA Survey Tool and any issues will be reported to the Administrator. This will be done weekly for one month until resolved by the main Quality Assessment and Assurance Committee. Reports will be presented to the weekly QA&A Committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA&A Committee. The weekly QA&A meeting is attended by the Director of Nursing, Wound Nurse, MDS Coordinator, Unit Manager, Therapy Director, Health Information Manager, Dietary Manager and the Administrator. Date of Compliance: October 26, 2015	
F 242 SS=D	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, a resident interview, staff interviews and medical record review, the facility failed to honor food preferences (dessert and beverages) for 1 of 4 sampled residents reviewed during meals for food preferences. (Resident	F 242	F 242 Corrective Action for Resident Affected; On October 1, 2015, the consultant	10/26/15

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F 242

Continued From page 4
#231)

The findings included:

Resident #231 was admitted to the facility on 04/02/15. Diagnoses included dysphagia.

A care plan dated 04/03/15 identified Resident #231 at risk for nutritional problems related to receipt of a mechanically altered diet, fluid restrictions and thickened liquids. Interventions included to provide the diet/fluids as ordered and honor preferences.

Review of the medical record for Resident #231 revealed a physician's order dated 06/19/15 for a 2000 mililiter (ml) fluid restriction, no added salt, double portions, mechanical soft diet with nectar thickened liquids (NTL) and a resident request for 2 salt packets and 8 ounces of tea with the lunch and dinner meals, tomato juice for breakfast, and fruit for dessert.

A quarterly minimum data set assessment dated 07/02/15 assessed Resident #231 with intact cognition, the ability to understand and be understood with communication, independent with eating and requiring a mechanically altered diet.

Resident #231 was observed on 09/30/15 from 12:49 PM until 1:00 PM in his room for lunch. Nurse Aide #1 (NA #1) brought Resident #231 his lunch meal, set-up the meal tray, and left the Resident's room. Resident #231 received a mechanical soft diet which included a hot dog with chili, French fries, mashed potatoes, cauliflower/broccoli mixed, cake, 2 salt packets, 4 ounces of NTL tea and 4 ounces NTL water. The

F 242

Registered Dietician visited resident #231 to review meal preferences. The consultant Registered Dietician also checked resident #231 tray card for accuracy and to ensure the resident choice is clearly noted on the tray card. The consultant Registered Dietician also did a follow up visit on October 22, 2015 with resident #231 with positive feedback from resident.

Corrective Action for Resident Potentially Affected;

All residents residing in the facility have the potential to be affected. All tray cards were audited by the consultant Registered Dietician and Dietary Services Director for accuracy. This audit was completed on October 8, 2015. All newly admitted residents are interviewed by the Dietary Services Director for food preferences/choices. Resident preferences are updated monthly.

Systemic Changes;

On October 22, 2015, an inservice was completed by the consultant Registered Dietician. All cooks and dietary aides, FT, PT & PRN employed by Gallins Food Services have completed that inservice as of October 22, 2015. The inservice included: Resident Choice; meeting with resident and noting these preferences on tray card. Monitoring the trayline to ensure that trays are accurate. Monitoring tray accuracy at point of service. Replacement of inaccurate or missing

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F 242	Continued From page 5 tray card on the lunch meal tray recorded that Resident #231 should have received 8 ounces of tea, instead of 4 ounces and fruit for dessert. Resident #231 sat up in bed and began to feed himself. He stated that he often did not receive the amount or type of fluids he requested, rarely received fruit for dessert and had mentioned this to staff so much that he just stopped saying anything anymore. Resident #231 was observed on 10/01/15 at 08:34 AM seated on his bed with his breakfast meal which included 8 ounces of NTL orange juice and 4 ounces of NTL water. Resident #231 did not receive tomato juice for breakfast per his preference. An interview occurred on 10/01/15 at 09:45 am with the certified dietary manager (CDM). During the interview the CDM expressed that Resident #231 had a physician's order for 2000 ml fluid restriction, but should receive fluids per his preference. The CDM also stated that residents' preferences were obtained during the completion of the initial dietary assessment upon admission and updated 30 days following admission with any changes. The CDM further stated that he had recently spoken to Resident #231, but that the Resident's food preferences were not discussed. The CDM stated that Resident #231 requested 2 salt packets with lunch/dinner meals, fruit for dessert and tomato juice for breakfast. The CDM stated that when a resident requested fruit for dessert, a fruit was usually provided, but since Resident #231 required NTL, a fruit cup was not provided since the juice in the fruit cup was not NTL consistency. The CDM then stated that other fruits could have been offered like applesauce	F 242	items during meals. Meal rounds by dietary staff and Resident Food Committee meetings to provide additional information to dietary services regarding resident satisfaction with their meals. Monitoring / Quality Assurance; To ensure compliance, the Dietary Services Director will monitor this issue using the QA Audit Tool and any issues will be reported to the Administrator. This will be done weekly for three months until resolved by the main Quality Assessment and Assurance Committee. Reports will be presented to the weekly QA&A Committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA&A Committee. The weekly QA&A meeting is attended by the Director of Nursing, Wound Nurse, MDS Coordinator, Unit Manager, Therapy Director, Health Information Manager, Dietary Manager and the Administrator. Date of Compliance: October 26, 2015	

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F 242	Continued From page 6 and bananas, but had not been offered to the Resident. The CDM stated he expected the dietary staff to provide residents with foods per their preference. An interview with the consultant registered dietitian (RD) occurred on 10/01/15 at 10:51 AM. The RD stated that Resident #231 did not receive foods per his preference due to problems with tray line accuracy. The RD also stated that Resident #231 should have received beverages and fruit per his preference. The RD further stated that dietary staff should have drained the juice off the fruit cup or given the Resident another fruit per his preference that was available. An interview with the director of nursing (DON) occurred on 10/01/15 at 11:43 AM. The DON stated that she expected nursing staff to set up a resident's meal tray and compare the resident's meal received to the tray card. If foods were missing, the DON stated she expected nursing staff to obtain any missing food items from dietary so that the resident received all of their food preferences. An interview with nurse aide #1 (NA #1) occurred on 10/01/15 at 3:27 PM and revealed that she set up the lunch meal for Resident #231 on 09/30/15. NA #1 stated that she looked at the diet and name of the resident on the tray card to make sure she gave the right meal tray to the right resident. NA #1 stated she knew Resident #231 liked to get 2 different beverages with his meals, but she did not notice that he should have received 8 ounces of iced tea and only received 4 ounces. NA #1 stated she also did not notice that	F 242		

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F 242	Continued From page 7 Resident #231 should have received fruit for dessert.	F 242		
F 278 SS=E	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 by: Based on record review and staff interviews, the facility failed to accurately code the Minimum	F 278	F 278	10/26/15

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F 278	Continued From page 8 Data Set for 3 of 3 residents (Resident #11, #44, and #246) identified as Level II PASRR residents, and 1 of 25 Stage 2 residents reviewed for cognition accuracy. The findings included: 1) Resident #11 had diagnoses including anxiety, and bipolar disorder. A review of Resident #11's comprehensive Minimum Data Set (MDS) dated 8/7/2015 indicated the resident was not considered by the state Level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness and/or intellectual disability. The results of this screening and review are used for formulating a determination of need, determination of an appropriate care setting and a set of recommendations for services to help develop an individual's plan of care. On 9/29/2015 the facility provided a list of residents who had been determined to have a Level II PASRR. Resident #11 was on the list. During an interview on 10/1/2015 at 4:38 PM, about coding Level II on the MDS, the MDS Coordinator said, "The Admissions Director is responsible for entering the PASRR number on the [resident's] face sheet." The MDS Coordinator indicated the face sheet was part of the resident's electronic clinical record. On 10/1/2015 at 5:36 PM, the Director of Admissions was interviewed about the accuracy of the electronic record regarding PASRR determination. The Director of Admissions said, "I just started this role about two months ago and yes, Admissions [Department] puts the PASRR number on the face sheet. I don't know why it wasn't on the face sheet for the residents who	F 278	Corrective Action for Resident Affected; Resident #11: Prior Comprehensive Assessment: Dated 8/7/2015. A Significant Correction to Prior Comprehensive Assessment (SCPA) was opened with an Assessment Reference Date of 10/14/2015. The Assessment Reference Date was set within 14days after the determination that a significant error in the prior comprehensive assessment occurred (ARD= Determination date 10/1/2015 + 14 calendar days). The Significant Correction to Prior Comprehensive Assessment completion date (item Z0500B) was 10/23/2015. (No later than 14days from ARD). The CAA(s) completion date (itemV0200B2) was 10/23/2015. (No later than 14days from ARD).The Care Plan completion date (Item V0200C2) was 10/23/2015. (No later than 7days after the CAA(s) completion date (item V0200B2) Resident #44: Prior Comprehensive Assessment: Dated 2/25/2015. A Significant Correction to Prior Comprehensive Assessment (SCPA) was opened with an Assessment Reference Date of 10/14/2015. The Assessment Reference Date was set within 14days after the determination that a significant error in the prior comprehensive assessment occurred (ARD= Determination date 10/1/2015 + 14 calendar days). The Significant Correction to Prior Comprehensive Assessment completion date (item Z0500B) was 10/23/2015 (No later than 14days from ARD). The CAA(s) completion date	

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F 278	Continued From page 9 have been here." During an interview about accuracy of the MDS on 10/1/2015 at 5:47 PM, the Director of Nursing indicated it was her expectation that Minimum Data Set would be 100% accurate. 2) Resident #44 had diagnoses including bipolar disorder and Dysthemic disorder. A review of Resident #44's comprehensive Minimum Data Set (MDS) dated 2/25/2015 indicated the resident was not considered by the state Level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness and/or intellectual disability. The results of this screening and review are used for formulating a determination of need, determination of an appropriate care setting and a set of recommendations for services to help develop an individual's plan of care. A review of the facility's list [provided on 9/29/2015] of Level II PASRR residents revealed that Resident #44 was included among the residents named on the list. During an interview on 10/1/2015 at 4:38 PM, about coding Level II on the MDS, the MDS Coordinator said, "The Admissions Director is responsible for entering the PASRR on the [resident's] face sheet." The MDS Coordinator indicated the face sheet was part of the resident's electronic clinical record. On 10/1/2015 at 5:36 PM, the Director of Admissions was interviewed about the accuracy of the electronic record regarding PASRR determination. The Director of Admissions said, "I just started this role about two months ago and yes, Admissions [Department] puts the PASRR	F 278	(itemV0200B2) was 10/23/2015 (No later than 14days from ARD).The Care Plan completion date (Item V0200C2) was 10/23/2015 (No later than 7days after the CAA(s) completion date (item V0200B2) Resident #246: Prior Comprehensive Assessment: Dated 4/29/2015. A Significant Correction to Prior Comprehensive Assessment (SCPA) was opened with an Assessment Reference Date of 10/14/2015. The Assessment Reference Date was set within 14days after the determination that a significant error in the prior comprehensive assessment occurred (ARD= Determination date 10/1/2015 + 14 calendar days). The Significant Correction to Prior Comprehensive Assessment completion date (item Z0500B) was 10/23/2015 (No later than 14days from ARD). The CAA(s) completion date (itemV0200B2) was 10/23/2015 (No later than 14days from ARD).The Care Plan completion date (Item V0200C2) was 10/23/2015 (No later than 7days after the CAA(s) completion date (item V0200B2) Corrective Action for Resident Potentially Affected; All residents who are determined to have a Level II PASRR have the potential to be affected by the alleged practice. PASRR numbers for all current residents where reviewed. 8 residents were determined to have a Level 11 PASRR. Audits of the most recent comprehensive assessment revealed that, 3 of the Minimum Data Set (MDS) indicated the resident(s) was not	

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F 278	Continued From page 10 number on the face sheet. I don't know why it wasn't on the face sheet for the residents who have been here." During an interview about accuracy of the MDS on 10/1/2015 at 5:47 PM, the Director of Nursing indicated it was her expectation that Minimum Data Set would be 100% accurate. 3) Resident #246 had a diagnosis of bipolar disorder. A review of Resident #246's comprehensive Minimum Data Set (MDS) dated 4/29/2015 indicated the resident was not considered by the state Level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness and/or intellectual disability. The results of this screening and review are used for formulating a determination of need, determination of an appropriate care setting and a set of recommendations for services to help develop an individual's plan of care. A review of the facility's list of Level II PASRR residents revealed that Resident #246 was included among the residents named on the list. During an interview on 10/1/2015 at 4:38 PM, about coding Level II on the MDS, the MDS Coordinator indicated for a resident who was a new admission, the Social Worker provided the information. For Resident #246, the MDS Coordinator said, "I know she was a Level II but I forgot to code it." During an interview about accuracy of the MDS on 10/1/2015 at 5:47 PM, the Director of Nursing indicated it was her expectation that Minimum Data Set would be 100% accurate. 4) Resident #330 was initially admitted to the	F 278	considered by the state Level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness and/or intellectual disability. A Significant Correction to Prior Comprehensive Assessment (SCPA) was opened with an Assessment Reference Date of 10/21/2015 for each respective resident to correct the alleged practice. Systemic Changes; On 10/26/2015 The RN MDS Coordinator was in serviced /educated on how to Complete section A1500 (Preadmission Screening and Resident Review) on the Minimum Data Set. Steps to complete for this item set was to complete if A0310A=01,03,04 or 05(Admission assessment, Annual Assessment, Significant Change in Status Assessment, Significant Correction to Prior Comprehensive Assessment). To review the Level 1 PASSR form to determine whether a Level 11 PASRR was required. Review the PASRR report provided by the State if Level 11 screening was required. Coding instructions for Section A1500 (Preadmission Screening and Resident Review). Code Yes: if PASRR Level 11 screening determined that the resident has a serious mental illness and/or ID/DD or related condition. All residents who are admitted to the facility must have a Level I PASRR completed to screen for possible mental illness (MI), intellectual disability (ID), (¿mental retardation¿ (MR) in federal regulation)/developmental disability (DD), or related conditions regardless of the	

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F 278 Continued From page 11

facility on 8/11/2015 and discharged on 8/15/2015.

The Discharge Minimum Data Set (MDS) dated 8/15/2015, indicated Resident #330 had intact long and short term memory. The MDS stated staff interviews had been conducted and those indicated the resident's speech was clear and she was independent and consistent for daily decisions. The MDS indicated Social Worker #1 had signed for the accuracy of the cognition assessment of Resident #330.

Review of the facility Progress note revealed an entry at 12:56 AM on 8/15/2015 by Nurse #2. The entry indicated a family member had approached the nurse on the 3-11 shift on 8/14/2015, to express concern that Resident #330 didn ' t recognize the family member. The documentation indicated nursing staff assessed the resident and the documentation included, "upon assessment noted resident is unable to communicate, altered mental status." The nursing note also indicated the physician had been notified and orders received.

Nurse #2 was not available for interview.

Another progress note was entered for 8/15/2015 at 11:32 PM by Nurse #3 which indicated the family member had again expressed concern about the resident's status, the physician was notified and the resident went out to the hospital.

Nursing Assistant (NA) #5, who had cared for Resident #330 on 8/14/2015 and on 8/15/2015 was interviewed on 10/1/2015 at 11:41 PM. NA#5 indicated the resident's speech could not be understood and that as the shift went on the

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resident¿s method of payment (please contact your local State Medicaid Agency for details regarding PASRR requirements and exemptions). Residents who have or are suspected to have MI or ID/DD or related conditions may not be admitted to the facility unless approved through Level II PASRR determination. Those residents covered by Level II PASRR process may require certain care and services provided by the nursing home, and/or specialized services provided by the State.
A resident with MI or ID/DD must have a Resident Review (RR) conducted when there is a significant change in the resident¿s physical or mental condition. Therefore, when a Significant Change in Status Assessment is completed for a resident with MI or ID/DD, the facility is required to notify the State mental health authority, intellectual disability or developmental disability authority (depending on which operates in their State) in order to notify them of the resident¿s change in status. Section 1919(e)(7)(B)(iii) of the Social Security Act requires the notification or referral for a significant change. 1 PASRRs are checked through NC MUST by the Admissions Director prior to admitting a resident to the facility.
The Director of Nursing or RN Designee will review new admissions/readmissions to ensure that each resident has a Level I PASRR completed to screen for possible mental illness (MI), intellectual disability (ID), (¿mental retardation¿ (MR) in federal regulation)/developmental disability (DD), or related conditions regardless of the

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F 278	Continued From page 12 resident became unresponsive. Social Worker (SW) #1 was interviewed on 10/1/2015 at 11:13 AM, regarding the assessment of the resident's speech and cognition. The SW indicated she had spoken to a family member and some facility staff about the resident on 8/14/2015. SW #1 stated she was aware the assessment period for Resident #330's MDS was supposed to include everything up to the night of 8/15/2015. The SW indicated she had not asked staff about the resident condition at discharge on 8/15/2015 and added, "I didn't realize the discharge would have an impact on the cognition." During an interview about accuracy of the MDS on 10/1/2015 at 5:47 PM, the Director of Nursing indicated it was her expectation that Minimum Data Set would be 100% accurate.	F 278	resident¿s method of payment (please contact your local State Medicaid Agency for details regarding PASRR requirements and exemptions). The Director of Nursing or RN Designee will ensure that each resident who has or is suspected to have MI or ID/DD or related conditions may not be admitted to the facility unless approved through Level II PASRR determination. If PASRR Level 11 screening determined that the resident has a serious mental illness and/or ID/DD or related condition the RN MDS Coordinator will code this in section A1500 of the comprehensive minimum data set assessment. For an individual known or suspected to have a mental illness, intellectual disability (¿mental retardation¿ in the regulation), or related condition (as defined by 42 CFR 483,102), a referral to the State Mental Health or Intellectual Disability/Developmental Disabilities Administration authority (SMH/ID/DDA) for a possible Level 11 PASRR evaluation must be made by the facility Social Worker. The Care Plan will be updated by the MDS Coordinator or RN Designee to reflect Level 11 PASRR. Any issues will be reported to the Director of Nursing or Administrator for appropriate action. During the daily Clinical Meeting (Monday through Friday), the RN MDS Coordinator or Designee will review assessment reference dates for all comprehensive assessments (Admission assessment, Annual Assessment, Significant Change in Status Assessment, Significant Correction to Prior Comprehensive Assessment) due for each day. The	

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F 278	Continued From page 13	F 278	review will include any resident determined to have PASRR Level 11. The RN MDS Coordinator will discuss about the PASRR Level 11 Authorization codes, timeframes and restrictions. Referrals for PASSR Level 11 renewals, and /or evaluations will be made by the facility Social Worker or Designee. The Daily Clinical Meeting is attended by the Director of Nursing, Unit Managers, MDS Coordinators, Support Nurse, Therapy, HIM, Dietary Manager, Social Worker, The Administrator and others as needed. Monitoring / Quality Assurance; To ensure compliance, the Director of Nursing or Designee will conduct a review using the QA Assessment Accuracy Tool. Five residents with Comprehensive assessments (Admission assessment, Annual Assessment, Significant Change in Status Assessment, Significant Correction to Prior Comprehensive Assessment) will be reviewed weekly for 4 weeks, and then monthly for three months. The items reviewed on the QA Assessment Accuracy Tool will include: Resident is determined to be a Level 11 PASRR, Section A1500 is coded accurately per Level 11 PASRR, CAA(s) is completed accurately, and Care plan is updated to reflect Level 11 PASRR. Identified issues will be reported immediately to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA	

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F 278	Continued From page 14	F 278	Meeting is attended by the Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, and the Administrator. Date of Compliance: October 26, 2015 F 278 part#2; Corrective Action for Resident Affected; Resident #330: A Modification Request was created for the combined PPS 5-Day / Unplanned Discharge /Start of Therapy Assessment with the Assessment Reference Date of 8/15/2015. This corrected record has all items included, not just the items in error. The Correction Request Section X items were completed on 10/21/2015 and includes the corrected record. Item A0050 has a value of 2, indicating a modification request. The Modification Request was submitted to the QIES ASAP system on 10/26/2015. Corrective Action for Resident Potentially Affected; All residents who are determined to have an OBRA (Unplanned Discharge assessment) and Medicare (PPS 5-Day) assessment combined when the Assessment Reference Dates windows overlap allowing for a common assessment reference date have the potential to be affected by the alleged practice. All residents who are determined to have an OBRA (Unplanned Discharge assessment) assessment have the potential to be affected by the alleged	

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F 278	Continued From page 15	F 278	practice. All combined PPS 5-Day/Unplanned Discharge assessments (In the last 6 months) were reviewed for the cognition assessment (Section C) accuracy. All Unplanned Discharge assessments (in the last 6 months) were reviewed for the cognition assessment (Section C) accuracy. 6 # of residents were determined to have combined PPS 5-Day/Unplanned Discharge Assessment submitted to the QIES ASAP system. A Modification Request was created for a combined PPS 5-Day / Unplanned Discharge assessment with inaccurate coding of the cognition assessment for the respective residents. The modification Requests were submitted to the QIES ASAP system on 10/26/2015 31 # of residents were determined to have Unplanned Discharge Assessment submitted to the QIES ASAP system. A Modification Request was created for an Unplanned Discharge assessment with inaccurate coding of the cognition assessment for the respective residents. The modification Requests were submitted to the QIES ASAP system on ¬¬¬10/26/2015. Systemic Changes; On 10/26/2015 The RN MDS Coordinator, Social Worker and any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated. The education focused on the Federal regulations at 42 CFR 483.20(b)(1)(xviii),(g), and (h) require that: The	

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F 278	Continued From page 16	F 278	assessment accurately reflects the residents status. A registered Nurse conducts or coordinates each assessment with the appropriate participation of health professionals. The assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts. An accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident¿s medical record, physician, and family, guardian, or significant other as appropriate or acceptable. The information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident¿s actual status was during the observation period) the interdisciplinary team completing the assessment. The Observation (Look Back) Period is the time period over which the resident¿s condition or status is captured by the MDS assessment. The observation period for a particular assessment for a particular resident will be chosen based upon the regulatory requirements concerning timing and the ARDs of previous assessment. Most MDS items themselves require an observation period, such as 7 or 14 days, depending on the item. Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the observation period must also cover this time period. When completing the MDS, only those occurrences during	

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F 278	Continued From page 17	F 278	the look back period will be captured. If it did not occur during the look back period, it is not coded on the MDS. Unplanned Discharge assessments may be combined with a PPS Medicare required assessment when requirements for all assessments are met. The use of the dash ¿-.¿ Is appropriate when the staff is unable to determine the response to an item, including the interview items. In some cases, the facility may have already completed some items of the assessment and should record those responses or may be in the process of completing an assessment. For unplanned discharges, the facility should complete the Discharge assessment to the best to its abilities. An unplanned discharge includes, for example: Acute-care transfer of the resident to a hospital or an emergency department in order to either stabilize a condition or determine if an acute-care admission is required based on emergency department evaluation or Resident unexpectedly leaving the facility against medical advice; or Resident unexpectedly deciding to go home or to another setting (e.g., due to the resident deciding to complete treatment in an alternate setting). Brief Interview for Mental Status should not be attempted because the resident is rarely/never understood, cannot respond verbally or in writing, or an interpreter is needed but not available. Then in that case a Staff assessment of Mental Status is completed. Brief Interview for Mental Status should be attempted because the resident is at least	

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F 278	Continued From page 18	F 278	sometimes understood verbally or in writing, and if an interpreter is needed, one is available. If a resident chooses not to answer a particular item, accept his or her refusal and move on the next questions. For C0200 through C0400, code refusals as incorrect. A resident can communicate but chooses not to participate in the BIMS and therefore does not attempt any of the items in the section C. This would be considered an incomplete interview; enter 99 for C0500, Summary Score, and complete the staff assessment of mental status. If an interview is stopped due to resident refusing to participate in the BIMS, then Code -, dash in C0400A, C0400B, and C0400C. Code 99 in the summary score in C0500. Code 1, YES in C0600 Should the Staff Assessment for Mental Status (C0700 ¿ C1000) is conducted? Then complete the Staff Assessment for Mental Status. The Director of Nursing or RN Designee will review combined PPS 5-Day/Unplanned Discharge assessments to ensure accurate coding for the cognition assessment (Section C: Cognitive Patterns) using the QA Assessment Accuracy tool. Any issues will be reported to the Director of Nursing or Administrator for appropriate action. During the daily Clinical Meeting (Monday through Friday), the RN MDS Coordinator or Designee will review assessment reference dates for all combined PPS 5-Day/Unplanned Discharge assessments due. The Daily Clinical Meeting is attended by the Director of Nursing, Unit Managers, MDS Coordinators, Support	

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F 278	Continued From page 19	F 278	Nurse, Therapy, HIM, Dietary Manager, Social Worker, The Administrator and others as needed. Monitoring / Quality Assurance; To ensure compliance, the Director of Nursing or Designee will conduct a review using the QA Assessment Accuracy Tool. Five residents with combined PPS 5-Day/Unplanned Discharge assessments and /or Unplanned discharge assessments will be reviewed weekly for 4 weeks, and then monthly for three months. The items reviewed on the QA Assessment Accuracy Tool will include: Section C : Cognitive Patterns; BIMS completed, Staff Assessment for Mental Status completed, Accuracy of Section C, Identified issues will be reported immediately to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, and the Administrator. Date of Compliance: October 26, 2015	
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.	F 312		10/26/15

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F 312	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to provide nail care for 1 of 4 sampled residents reviewed for activities of daily living (Resident #73). The findings included: Resident #73 was admitted to the facility on 10/08/13. Diagnosis included general muscle weakness, congestive heart failure and hypertension. A review of the most recent Quarterly Minimum Data Set (MDS) dated 07/08/15 revealed Resident #73 was able to make self-understood and has the ability to understand others. The MDS further revealed Resident #73 required extensive assistance with activities of daily living which included personal hygiene. A review of a care plan with an onset date of 07/08/15 revealed Resident #73 required assistance with activity daily living. The interventions included the following: · Check nail length and trim and clean as necessary. Report any changes to the nurse. · Staff assistance with grooming and personal hygiene During an observation on 10/01/15 at 7:50 AM Resident #73 was sitting up in bed and all ten fingernails on his hands were long and extended approximately ¼ inch at the end of each finger. Resident #73 fingernails had dark matter under	F 312	F 312 Corrective Action for Resident Affected; On October 1, 2015, resident #73 nails were trimmed and cleaned by assigned CNA. Corrective Action for Resident Potentially Affected; All residents residing in the facility have the potential to be affected. On October 24, 2015, all Certified Nursing Assistants cleaned and trimmed all patients nails who required cleaning or trimming. Systemic Changes; On 10/23/15 the DON and/or designee inserviced the full time, part time and prn Certified Nursing Assistants and Nurses. Topics included: Nail care should be provided any time there are substances under the nails or if require trimming. Typically trimming of nails is completed during shower days, however, it should be completed any time there is a need. Nail care includes cleaning any substances from under the nails. It also includes trimming nails. Nails should be trimmed based on resident preferences for length if the patient is able to verbalize their wishes. Nails that have rough or jagged	

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F 312	Continued From page 21 all nails on both hands. The right thumb fingernail was broken and jagged. During an observation on 10/01/15 at 8:20 AM Resident #73 was sitting up in bed and all ten fingernails on his hands were long and extended approximately ¼ inch at the end of each finger. Resident #73 fingernails had dark matter under all nails on both hands. The right thumb fingernail was broken and jagged. During an observation on 10/01/15 at 8:40 AM Resident #73 was sitting in up in bed and all ten fingernails on his hands were long and extended approximately ¼ inch at the end of each finger. Resident #73 fingernails had dark matter under all nails on both hands. The right thumb fingernail was broken and jagged. During an interview with the observation on 10/01/15 at 9:20 AM revealed Resident #73 stated he had a shower on 09/30/15 but his nails were not trimmed or clean. During the interview, Resident #73 stated he wanted his nails clean because it would make him feel better. Resident #73 explained he reported to staff several times to clean his nails. Interview on 10/01/15 at 11:16 AM Nurse Aide (NA) #1 stated Resident #73 had showers on the 7:00 AM to 3:00 PM shift on Wednesday and Saturday of each week. She stated NAs were expected to provide nail care which included cleaning under the nails and trimming them during their showers. She further stated she had not trimmed or cleaned Resident #73's nails on his scheduled shower days. On 10/01/15 at 11:17 AM Nurse#1 was	F 312	edges should be trimmed or filed to be smooth. Nail care is provided by Certified Nursing Assistants unless the resident is a diabetic. If the resident is a diabetic, the Nurses should complete the required nail care. This information has been integrated into the standard orientation training and in the required inservice refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring / Quality Assurance; The Director of Nursing and/or designee will monitor this issue using the QA Survey Tool. This will be accomplished by observing at least 10 residents weekly to ensure that nails are clean and trimmed appropriately. Any issues will be reported to the Administrator. This will be done weekly for one month, then monthly x3 months until resolved by the main Quality Assessment and Assurance Committee. Reports will be presented to the weekly QA&A Committee by the Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA&A Committee. The weekly QA&A meeting is attended by the Director of Nursing, Wound Nurse, MDS Coordinator, Unit Manager, Therapy Director, Health Information Manager, Dietary Manager and the Administrator.	

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(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 312	Continued From page 22 accompanied to Resident #73's room to observe Resident #73's fingernails. Nurse#1 confirmed Resident #73 needed the dark matter cleaned from under all ten fingernails. Nurse#1 stated Resident #73 nails should be trimmed and clean during shower days and clean once a week and as needed. During an interview on 10/01/15 at 11:55 AM the Assistant Director of Nursing stated it was her expectation that nail care be done during the shower days, once a week and as needed. During an interview on 10/01/15 at-6:05 PM the Director of Nursing stated it was expectation for staff to do routine nail care for residents once a week and as needed.	F 312	Date of Compliance: October 26, 2015	
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this	F 353		10/26/15

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F 353	Continued From page 23 section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews and a resident interview (#119), the facility failed to provide sufficient nursing staff to ensure 1 of 4 sampled residents (Resident #73) received nail care and ensure meals were served at a palatable temperature during 2 of 3 meals observed (Resident #223). The findings included: 1. Cross refer F 312 Based on observations, record reviews and staff interviews the facility failed to provide nail care for 1 of 4 sampled residents reviewed for activities of daily living (Resident #73). 2. Cross refer F 364 Based on review of Resident Council meeting minutes (September 2015), 2 of 3 dining observations, 6 resident interviews (Residents #223, #335, #231, #54, #103, and #96), 1 of 1 tray line observation, Food Committee meeting minutes for 2 months (August 2015 and September 2015) staff interviews, and review of medical records, the facility failed to provide palatable foods to residents based on preferences for temperature and taste. 3. During an interview on 9/28/2015 at 3:05 PM, Resident #119 indicated there was not enough staff to make sure necessary assistance was provided in a timely manner. Resident #119 stated she is continent of urine but there were times when she pressed the call bell for assistance but had an accident before the call	F 353	F 353 Corrective Action for Resident Affected; On October 16, 2015, the Administrator advised patients #119, 223,335, 231, 54, 103, 96 to notify him if staffing issues prohibited them from having care needs met or if food was not served at the proper temperatures. On October 1, 2015, resident #73 nails were trimmed and cleaned by assigned CNA. Corrective Action for Resident Potentially Affected; All residents have the potential to be affected by this practice. On October 21, 2015, the Administrator met with the resident council and food committee to discuss this plan of correction. Systemic Changes; On October 24, 2015, the DON and Designee inserviced the full time, part time and prn Certified nursing assistants and nurses. Topics included: Staff is expected to provide necessary care for the patients according to the task assignments and plan of care. When we have call outs, attempts will be made by	

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bell was answered on 3rd shift.

On 9/30/2015 at 2:47 PM, Nurse #4 was interviewed. Nurse #4 said staff call out sick 3 to 4 times a week and it happens on all the shifts. The nurse added that when working short staffed, incontinent care is not every two hours but is done at least twice per shift.

An interview was conducted with nurse aide (NA) #6 on 9/30/2015 at 2:55 PM. NA#6 said they work short about 5 to 6 times a week. The NA stated they do the best they can but that it takes longer to answer call lights, sometimes showers are cancelled and they can only provide incontinent care twice per shift.

During an interview on 9/30/2015 at 2:57 PM, NA#7 said they work short 4 or 5 days per week. The NA said when they are short on staff showers are cancelled and it takes a lot longer to answer call lights too.

An interview was conducted with NA#8 on 9/30/2015 at 3:00 PM. NA#8 stated that when they work short staffed, residents are not repositioned every two hours. NA #8 said they work short staffed at least 4 to 5 times a week and there is not enough time to completely feed residents either.

On 9/30/2015 at 4:05 PM NA#9 was interviewed. NA#9 said they are short staffed about 2 to 3 times a week on the 3 to 11 shift. She stated care is provided but, "resident care just gets rushed at times."

During an interview on 9/30/2015 at 4:07 PM, NA# 2 stated the day shift work short about 3 to 4

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the staffing coordinator to find replacements. Staff shall utilize the on-call procedure anytime during the day, night or on weekends immediately upon notification of another staff¿s absence. If you are not able to get the patient care completed in a timely fashion notify your direct supervisor. Nurses are to observe all residents to ensure that care is being provided with the scheduled staffing pattern. If they do note that care is lacking they should address the concern with the nursing assistant to determine the cause. If the care cannot be provided due to staffing, they must call the RN on call to see what other staffing options can be implemented to meet the patient needs. This may include calling in extra staff or agency utilization with Administration notification and approval only.

This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.

Monitoring / Quality Assurance;

The Director of Nursing and/or designee will monitor this issue using the QA Survey Tool. This will be accomplished by observing at least 10 residents weekly to ensure that nails are clean and trimmed appropriately, and, 10 residents weekly to ensure that meal trays are delivered so that food is palatable. Any issues will be reported to the Administrator. This will be

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F 353	Continued From page 25 times a week on days shift. On 10/02/15 at 1:16 PM, the Administrator indicated his expectation would be to provide appropriate staffing to respond to resident needs.	F 353	done weekly for one month, then monthly x3 months until resolved by the main Quality Assessment and Assurance Committee. Reports will be presented to the weekly QA&A Committee by the Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA&A Committee. The weekly QA&A meeting is attended by the Director of Nursing, Wound Nurse, MDS Coordinator, Unit Manager, Therapy Director, Health Information Manager, Dietary Manager and the Administrator. Date of Compliance: October 26, 2015	
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: Based on observations, staff interviews and record review the facility failed to provide 4 ounce portions of fortified pudding per preplanned menu for 25 of 25 residents on fortified diets on the fortified diet list. Findings included: Record review: A review of the fortified food menu stated that a calorie dense pudding serving	F 363	F 363 Corrective Action for Resident Affected; No specific resident is identified. Corrective Action for Resident Potentially Affected;	10/26/15

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F 363	Continued From page 26 size was 4 ounces (oz). An observation on 9/30/2015 at 10:20 AM revealed there was pudding, applesauce and dump cake prepared in portion size cups on trays and on a rack in the refrigerator. An interview with the dietary manager on 9/30/2015 at 10:20 AM while on tour of the kitchen revealed the cups were 4 oz. He stated that it was fortified pudding in the cups. He stated that the amount of pudding in each cup was 2-3 oz. An observation on 10/1/2015 at 11:15 AM was made of the tray line while lunch was being served. A cup of fortified pudding was placed on a resident's tray and the tray was loaded in the cart to go out to the floor to be served. The dietician was at the tray line and was asked to measure the amount of pudding in the cup from that resident's tray on the cart. The amount measured 3.5 teaspoons which is less than the 4 oz. portion. The dietician did the conversion and confirmed the amount in the cups was less than the required 4 oz. portion. Her expectation was that the portion sizes were correct per the menu requirements. The dietician stated they were putting two cups of fortified pudding on the trays at lunch to give the required portion size of fortified pudding to each resident on a fortified diet.	F 363	All residents residing in the facility have the potential to be affected. All menu items are to be prepared and portioned according to recipe and menu spreadsheets. Compliance will be monitored by the Dietary Services Director. Meal trays will be checked for accuracy prior to leaving the kitchen. Systemic Changes; On October 22, 2015, an inservice was completed by the consultant Registered Dietician. All cooks and dietary aides, FT, PT & PRN employed by Gallins Food Services have completed that inservice as of October 22, 2015. The inservice included: Meeting resident¿s nutritional needs by ensuring that items are prepared according to recipe and that appropriate portions are served. Monitoring / Quality Assurance; To ensure compliance, the Dietary Services Director will monitor this issue using the QA Audit Tool and any issues will be reported to the Administrator. This will be done weekly for three months until resolved by the main Quality Assessment and Assurance Committee. Reports will be presented to the weekly QA&A Committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA&A Committee. The weekly QA&A meeting is attended by the Director	

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F 363	Continued From page 27	F 363	of Nursing, Wound Nurse, MDS Coordinator, Unit Manager, Therapy Director, Health Information Manager, Dietary Manager and the Administrator. Date of Compliance: October 26, 2015	
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 review of Resident Council meeting minutes (September 2015), 2 of 3 dining observations, 6 resident interviews (Residents #223, #335, #231, #54, #103, and #96), 1 of 1 tray line observation, Food Committee meeting minutes for 2 months (August 2015 and September 2015), staff interviews, and review of medical records, the facility failed to provide palatable foods to residents based on preferences for temperature and taste. The findings included: 1 a. Review of the Resident Council Meeting minutes for September 2015, revealed, "Multiple residents expressed that there needs to be more help at meal time; that they are not getting what they need and food sits for too long." The facility responded to the food grievance on 9/21/2015 with, "We have added staff to assist in	F 364	F 364 Corrective Action for Resident Affected; Multiple residents were affected. Resident #223¿s concerns were immediately resolved on 9-28-15, 9-30-15 and on 10-1-15 via NA reheating of resident tray per his satisfaction. Corrective Action for Resident Potentially Affected; All residents residing in the facility have the potential to be affected. All menu items are to be prepared according to recipe and tasted. Endpoint and serving temperatures are taken. Temperatures are logged on temp form. Meals will be delivered using appropriate insulated	10/26/15

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meal tray pass."
During an interview on 9/29/2015 at 11:21 AM, the Resident Council President stated the staff work hard but she thought they needed more staff in the dining room."

1 b. Resident #223's most recent Minimum Data Set, dated 7/10/2015, indicated he was cognitively intact for daily decision making.

During an interview on 9/28/2015 at 8:41AM, Resident #223 had just received his breakfast tray. The resident removed the insulating dome from his plate, put butter on his oatmeal and indicated that breakfast frequently arrived cold. Observation revealed the butter did not melt on his oatmeal and the gravy with meat had congealed. Resident #223 put on the call bell to have meal reheated.

On 9/30/2015, two carts arrived on the hall with breakfast trays. The first one arrived at 8:05 AM and the one containing Resident #223's breakfast arrived at 8:18 AM. Resident #233's tray was delivered to his room at 8:44 AM. The resident indicated that when the trays came late, the breakfast was always cold. Before the Nursing Assistant (NA) put it down on the over-bed table, Resident #223 requested that the meal be reheated.

On 10/1/2015, the cart with Resident #233's tray arrived on the unit at 8:31 AM. Resident #223's tray was delivered to his room at 8:53 AM. The resident put the butter on the oatmeal and covered it with a pancake. The resident indicated the pancake was to hold in the heat so the butter would melt. Resident #223 said the eggs were cold and observation revealed the gravy with

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service ware and on scheduled.
Compliance will be monitored by the Dietary Services Director.

Systemic Changes;

On October 22, 2015, an inservice was completed by the consultant Registered Dietician. All cooks and dietary aides, FT, PT & PRN employed by Gallins Food Services have completed that inservice as of October 22, 2015. The inservice included: Serving residents palatable food by ensuring that items are prepared according to recipe, tasted and served at appropriate temperature. Trays are served attractively in appropriate service ware and delivered according to meal schedule.

Monitoring / Quality Assurance;

To ensure compliance, the Dietary Services Director will monitor this issue using the QA Audit Tool and any issues will be reported to the Administrator. This will be done weekly for three months until resolved by the main Quality Assessment and Assurance Committee. Reports will be presented to the weekly QA&A Committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA&A Committee. The weekly QA&A meeting is attended by the Director of Nursing, Wound Nurse, MDS Coordinator, Unit Manager, Therapy Director, Health Information Manager,

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F 364	Continued From page 29 meat had begun to congeal. A minute later the resident removed the pancake from the oatmeal and the butter had not melted. The resident put on his call bell and when NA #3 came to the room at 8:58 AM, Resident #223 requested the meal be reheated. NA #3 returned the reheated food at 9:02 AM and the resident indicated it was heated to his satisfaction. NA #3 was interviewed on 10/1/2015 at 9:16 AM. NA#3 indicated that when the trays were out early then the food tended to be hotter and Resident #223 was okay with the food temperature. NA#2 added that when the food carts came out later, then Resident #223 usually would ask to have it reheated. At 9:21 AM on 10/1/2015, NA#4 indicated Resident #223 did not like cold food and frequently requested to have his plate reheated. During an interview on 10/1/2015 at 5:56 PM, the Director of Nursing indicated it was her expectation that residents receive palatable food at the proper temp. c. A nursing admission assessment for Resident #335 dated 09/16/15 assessed him alert and oriented to person, place, and situation, with some confusion related to time and independent with eating. Resident #335 was observed on 09/28/15 at 08:58 AM eating breakfast, which included scrambled eggs and bacon, in the dining area. During the observation, Resident #35 stated that his eggs were often received runny and his bacon was rubbery. A Follow-up interview occurred with Resident #335 on 09/29/15 at 2:27 PM. During the interview, Resident #335 stated that the food was not good, does not have a good taste, bacon was like rubber and eggs were runny and lumpy.	F 364	Dietary Manager and the Administrator. Date of Compliance: October 26, 2015	

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F 364	Continued From page 30 During an interview on 10/1/2015 at 5:56 PM, the Director of Nursing indicated it was her expectation that residents receive palatable food at the proper temp. d. A quarterly minimum data set for Resident #231 dated 07/02/15 assessed him with intact cognition and independent with eating. Resident #231 was interviewed on 09/29/15 at 09:51 AM and stated "They need a better cook." Resident #231 described the food as too salty sometimes and gave ham as an example and that he often received cold food for all meals. During an interview on 10/1/2015 at 5:56 PM, the Director of Nursing indicated it was her expectation that residents receive palatable food at the proper temp. e. A quarterly minimum data set for Resident #54, dated 08/15/15 assessed her with intact cognition and independent with eating. Resident #54 was interviewed on 09/30/15 at 5:02 PM and stated "The food is not good, turkey bacon you can't even pull it apart, it's so tough." Resident #54 further described that some food was served undercooked. Examples given included chicken served undercooked and pink and collards served too tough to chew. Resident #54 stated that staff was made aware, but "it does no good, they serve what they want to serve." During an interview on 10/1/2015 at 5:56 PM, the Director of Nursing indicated it was her expectation that residents receive palatable food at the proper temp.	F 364		

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F 364	Continued From page 31 f. Resident #103 was observed on 09/28/15 at 8:22AM eating breakfast which included scrambled eggs and grits in her room. During the observations, Resident #103 stated her eggs and grits were often received cold. Resident #103 stated her food was not good and does not have a good taste. Review of the quarterly minimum data set dated 07/03/15 revealed Resident #103 had short and long term memory loss and severely impaired to making daily decisions. The assessement revealed Resident #103 was able to make her self-understood and has the ability to understand others. The assessment further specified Resident #103 required extensive assistance with most of her activities of daily living and supervision with eating. On 09/28/15 at 8:22 AM Resident #103 was interviewed. Resident #103 stated her breakfast meal was always served cold, especially the eggs, and the grits were cold. Resident #103 further stated she would prefer to have hot foods served to her but the eggs were always served cold. During an interview on 10/1/2015 at 5:56 PM, the Director of Nursing indicated it was her expectation that residents receive palatable food at the proper temp. g. Resident #96 was observed on 09/28/15 at 8:34 AM eating breakfast which included scrambled eggs and grits in her room. During the observations, Resident #96 stated his eggs and grits were often received cold. Resident #96	F 364		

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F 364	Continued From page 32 stated his food was not good and always served cold. Review of the quarterly minimum data set dated 07/02/15 revealed Resident #96 required supervision with eating and setup help. The assessment revealed Resident #96 cognition was intact and he was capable of making his needs known. Resident #96 required extensive assistance with most of his activities of daily living and required supervision with eating. On 09/28/15 at 8:34 AM Resident #96 was interviewed. Resident #96 was observed eating breakfast in his room. Resident #96's breakfast meal was observed and he revealed he was served scrambled eggs and grits that were cold and thick. Resident #96 further stated he would prefer to have hot foods served to him but the eggs and grits were always served cold. During an interview on 10/1/2015 at 5:56 PM, the Director of Nursing indicated it was her expectation that residents receive palatable food at the proper temp. h. Observation 10/1/2015 at 7:15 AM of breakfast being served by DM (Dietary Manager) on the tray line revealed the temperature of the sausage links was 125 degrees Fahrenheit (F). The bacon was 116.9 F. Scrambled eggs 135 degrees F, DM put this pan back into the warmer and brought out another pan that that temped at 170 degrees. Oatmeal was 172 degrees, ground beef 153 degrees, pureed meat 144 degrees F, sausage links put back in the warmer, then DM cooked other sausage links in the fryer-temp 175 when taken out of the fryer. Sausage patties	F 364		

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F 364	Continued From page 33 came out of oven. The DM decided not to serve them. Turkey bacon was put back in the convection oven off the tray line due to not being hot enough. On 10/1/2015 at 7:15 AM an interviewed with the DM indicated that his expectation was the food being served should be at the correct temperatures for each item. During an interview 10/1/2015 5:56 PM the Director of Nursing indicated that it was her expectation that residents receive palatable foods at the correct temperature.	F 364		
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on meal observations, a resident interview, staff interviews and medical record review, the facility failed to provide a double portions diet per physician's order to a resident at risk for nutritional deficits for 1 of 5 sampled residents reviewed for nutrition. (Resident #231) The findings included: Resident #231 was admitted to the facility on 04/02/15. Diagnoses included hypertension, Hepatitis C, dysphagia, hemiplegia, cerebral infarction, atrial fibrillation, and thrombocytopenia. Weight on admission was 172 pounds. A care plan dated 04/03/15 identified Resident	F 367	F 367 Corrective Action for Resident Affected; Resident #231 was visited by the consultant Registered Dietician on 10-1-15 to review meal preferences. Also, Resident #231 tray card was checked by the consultant Registered Dietician on 10-1-15 to ensure that resident¿s choice is clearly noted on tray card and that double portions are indicated. The consultant Registered Dietician also did a follow up visit on October 22, 2015 with resident #231 with positive feedback from resident. On October 2, 2015 resident #231 plan of	10/26/15

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	345026	A. BUILDING ______ B. WING ______	C 10/02/2015

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F 367	Continued From page 34 #231 at risk for nutritional problems related to receipt of a mechanically altered diet, thickened liquids and fluid restrictions. Interventions included to provide the diet as ordered, obtain and monitor lab/diagnostic results as ordered. Review of the medical record for Resident #231 revealed a physician's order dated 06/19/15 for a 2000 ml fluid restriction, no added salt, double portions, mechanical soft diet with nectar thickened liquids. A quarterly minimum data set assessment dated 07/02/15 assessed Resident #231 with intact cognition, the ability to communicate and understand and be understood, independent with eating. Review of a RD progress note dated 09/30/15 documented that Resident #231 was referred for weight loss. He had a current body weight of 173 pounds, assessed as mild 3.9% loss for 30 days, 13.7% loss for 90 days and stable since the initial admission weight of 172 pounds. The RD recorded that she questioned the accuracy of some weights due to varying from 170-200 pounds and attributed some weight variances likely due to fluid restrictions and edema. The RD progress note also indicated that Resident #231 continued to receive a double portions diet and recommended fortified foods with breakfast, lunch and dinner meals due to continued weight loss. Resident #231 was observed on 09/30/15 from 12:49 PM until 1:00 PM in his room for lunch. Nurse Aide #1 (NA #1) brought Resident #231 his lunch meal, set-up the meal tray, and left the	F 367	care was reviewed by the IDT. Corrective Action for Resident Potentially Affected; All residents residing in the facility have the potential to be affected. All tray cards were audited for accuracy by the Dietary Services Director and that audit was completed as of October 22, 2015. Systemic Changes; On October 22, 2015, an inservice was completed by the consultant Registered Dietician. All cooks and dietary aides, FT, PT & PRN employed by Gallins Food Services have completed that inservice as of October 22, 2015. The inservice included: Following the Medical Director¿s orders by ensuring that correct diet portions are served. Monitoring tray accuracy at point of service. Replacement of inaccurate or missing items. Meal rounds by dietary staff and Resident Food Committee meetings to provide additional information to dietary services regarding resident satisfaction with their meals. Monitoring / Quality Assurance; To ensure compliance, the Dietary Services Director will monitor this issue using the QA Audit Tool and any issues will be reported to the Administrator. This will be done weekly for three months until resolved by the main Quality Assessment and Assurance Committee. Reports will	

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F 367	Continued From page 35	F 367		

Resident's room. Resident #231 received a mechanical soft diet which included one hot dog with chili, 6 French fries, 1 serving mashed potatoes, 1 serving cauliflower/broccoli mixed, 1 piece of cake, 2 salt packets, 4 ounce of nectar thickened tea and 4 ounce nectar thickened water. The tray card on the lunch meal tray recorded that Resident #231 should have received a double portions diet. Resident #231 sat up in bed and began to feed himself. He stated that he was supposed to receive a double portions diet, but often did not receive it and at times he was still hungry after receipt of his meals. Resident #231 stated he had previously mentioned to staff that he did not always get a double portions diet and that he just stopped saying anything anymore and supplemented with snacks.

Resident #231 was observed on 10/01/15 at 08:34 AM seated on his bed with his breakfast meal which included 8 ounces of nectar thickened orange juice, 4 ounces of nectar thickened water, a single portion of eggs, a single portion of chopped sausage, a single portion of grits, a single portion of oatmeal, and 2 pancakes. Resident #231 stated he did not receive double portions for breakfast again. Resident #231 stated he ate his grits and pancakes but did not eat the eggs, sausage or oatmeal.

An interview and observation of Resident #231's breakfast meal occurred on 10/01/15 at 9:45 AM with the CDM. During the observation, the CDM removed the breakfast meal for Resident #231, measured the uneaten eggs, sausage and oatmeal and stated that Resident #231 did not

be presented to the weekly QA&A Committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA&A Committee. The weekly QA&A meeting is attended by the Director of Nursing, Wound Nurse, MDS Coordinator, Unit Manager, Therapy Director, Health Information Manager, Dietary Manager and the Administrator.

Date of Compliance: October 26, 2015

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F 367	Continued From page 36 receive double portions for these items. The CDM stated that Resident #231 should have received double portions for all foods. The CDM stated he was not aware that Resident #231 was not receiving a double portions diet. An interview occurred on 10/01/15 at 10:51 AM with the RD and revealed that she received a recent referral from the director of nursing (DON) for Resident #231 regarding continued weight loss. The RD stated that she was not aware that Resident #231 had not received a double portions diet as ordered. The RD further stated that Resident #231 should have received a double portions diet as ordered for weight management and previous complaints of not getting enough to eat. The RD also stated that some of the weight variance for Resident #231 may be attributed to inaccurate/inconsistent weights, not receiving a double portions diet and changes in fluid volume. An interview with the DON occurred on 10/01/2015 at 11:43 AM and revealed that the facility had a weight committee, which included the DON and CDM that met weekly to discuss residents who had lost weight. The DON also stated that she expected Resident #231 to receive his double portions diet as ordered.	F 367		
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	F 371		10/26/15

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F 371	Continued From page 37 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to keep hot foods above 135 degrees on the on the steam table. Findings include: Observation 10/1/2015 7:15am of breakfast being served by DM (Dietary Manager) on the steam table revealed the temperature of the sausage links was 125 degrees Fahrenheit. The scrambled eggs were 135 degrees Fahrenheit. An interview on 10/1/2015 at 4:16 PM with the evening cook indicated that she takes the temperature of her foods before starting to serve each meal and records the temperatures on the temperature log. If the temperature is not warm enough she puts the food back in the warmer. A review of the temperature logs 9/9/2015-9/30/2015 on 10/1/2015 at 4:20 PM revealed that on 9/22/2015 the hot cereal temperature recorded was 32 degrees. On 9/25/2015 the temperature for hot cereal temperature recorded was 42 degrees. There was no temperature log for 9/9/2015. An interview with the DM 10/1/2015 4:20 pm indicated the two low temperatures for hot cereal must be a mistake since the hot cereal is listed above the milk on the log. He stated he reviews the temperature logs daily and watches the cooks take the temperature the food for lunch and dinner. An interview 10/1/2015 at 7:15am with the dietary manager indicated that his expectation was the food served would be at the correct temperatures for each item.	F 371	F 371 Corrective Action for Resident Affected; No specific resident is identified. Corrective Action for Resident Potentially Affected; All residents residing in the facility have the potential to be affected. All menu items are to be held and served at the appropriate temperatures. Endpoint and trayline holding temperatures are to be taken and documented on the temperature log. Corrective action (reheating) is to be conducted when items are not at appropriate temperature. Compliance will be monitored by the Dietary Services Director. Systemic Changes; On October 22, 2015, an inservice was completed by the consultant Registered Dietician. All cooks and dietary aides, FT, PT & PRN employed by Gallins Food Services have completed that inservice as of October 22, 2015. The inservice included: Serving safe food by ensuring that food is cooked to the minimum internal cooking temperature and that hot foods are served above 135 degrees.	

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F 371	Continued From page 38 An interview 10/1/2015 5:56pm the Director of Nursing indicated that it was her expectation the residents receive palatable foods at the correct temperature.	F 371	Monitoring / Quality Assurance; To ensure compliance, the Dietary Services Director will monitor this issue using the QA Audit Tool and any issues will be reported to the Administrator. This will be done weekly for three months until resolved by the main Quality Assessment and Assurance Committee. Reports will be presented to the weekly QA&A Committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA&A Committee. The weekly QA&A meeting is attended by the Director of Nursing, Wound Nurse, MDS Coordinator, Unit Manager, Therapy Director, Health Information Manager, Dietary Manager and the Administrator. Date of Compliance: October 26, 2015	