STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345143	A. BUILDING _____ B. WING _____	C 10/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET SILER CITY, NC 27344

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation Event ID #4R8Y11.	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the	F 278	1. Modifications were made to the	11/18/15

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

Electronically Signed | 11/12/2015

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F 278	Continued From page 1 facility failed to accurately code the Minimum Data Set (MDS) assessment for pressure ulcer (Resident #25) and for hydration (Resident #42) for 2 of 23 sampled residents reviewed. Findings included: 1. Resident #42 was admitted to the facility on 1/25/15. The quarterly Minimum Data Set (MDS) assessment dated 9/21/15 indicated that Resident # 42 had severe cognitive impairment and was dehydrated. The doctor's progress notes were reviewed. The last notes dated 9/4/15 did not address dehydration. The nurse's notes were reviewed. The notes dated 9/18/15 at 3:08 AM indicated that Resident #42 was treated with Tylenol (fever reducer) for temperature of 101.2 degrees Fahrenheit (F) and at 5:52 PM, the resident was treated with Rocephin (antibiotic) for increased congestion and coughing. The notes dated 9/19/15 at 1:00 PM and 7:00 PM indicated that the resident's food and liquid intake were adequate. The notes dated 9/20/15 at 8:00 PM indicated that the resident's food and liquid intake were adequate. On 10/21/15 at 4:15 PM, the MDS Nurse was interviewed. She stated that she had not seen any documentation in the records to indicate that Resident #42 had dehydration. She added that the nurse's notes indicated that the resident had adequate food and liquid intake so the MDS Nurse acknowledged that the coding for hydration was inaccurate. 2. Resident #25 was readmitted to the facility on 9/7/15 status post below the knee amputation of the right leg. The quarterly Minimum Data Set	F 278	Minimum Data Set for Resident #42 and Resident #25 on 10/21/2015. The modification for Resident #42 included changing the dehydration status from yes to no and the modification for Resident #25 was changed from present on admission to in-house acquired. 2. Director of Nursing, Assistant Director of Nursing and Clinical Reimbursement Coordinator completed audit on 11/10/2015 of Minimum Data Set for those residents who were coded for dehydration and pressure ulcers. Audits revealed 2 Minimum Data Sets were coded incorrectly for pressure ulcers. Modifications were completed on 11/10/2015 by Clinical Reimbursement Coordinator. 3. Regional Clinical Reimbursement Coordinator will provide re-education to Clinical Reimbursement Coordinator on MDS accuracy 11/16/2015. The Interdisciplinary Team, including Director of Nursing, Clinical Reimbursement Coordinator, Recreation Director, Social Worker and Register Dietitian will review Minimum Data Set for accuracy prior to transmission on 100% of residents x 4 weeks then 50% of residents x 4 weeks then 25% of residents x 4 weeks and 10% of residents quarterly thereafter. 4. The center Clinical Reimbursement Coordinator will present the results of the audit for accuracy for the entire Minimum Data Set that was completed prior to submission monthly to the Performance	

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F 278	Continued From page 2 (MDS) dated 10/5/15 indicated that Resident #25's cognition was intact and she had an unstageable pressure ulcer that was present on admission. The nursing admission assessment dated 9/7/15 indicated that the resident was admitted with skin impairment on the buttock/sacrum and right stump. The records indicated that Resident #25 was admitted with a stage II pressure ulcer on the buttock/sacrum and the pressure ulcer healed up on 9/27/15. The nurse's notes were reviewed. The notes dated 9/15/15 at 11 AM indicated that an area was noted to the right inner knee and it appeared to be from the stump brace. On 9/18/15, the skin integrity report indicated that an unstageable pressure ulcer was first identified on the right medial knee. The ulcer had 90% slough and 10% granulation measuring 1.5 centimeter (cm) x (by) 5.3 cm. On 9/19/15, there was a physician's order to clean the right medial knee with vashe (wound cleanser), apply nickel size santyl (debriding agent) to wound bed, cover with foam, wrap with kerlix and to change it daily and as needed. On 10/21/15 at 11:05 AM, the MDS Nurse was interviewed. After reviewing the records, the MDS Nurse stated that the pressure ulcer was coded incorrectly. The unstageable pressure ulcer had developed in house and was not present on admission.	F 278	Improvement meeting for 3 months then quarterly.	
F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET	F 281		11/18/15

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F 281 SS=E	Continued From page 3 PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to correctly transcribe a medication as ordered by the physician, to the Medication Administration Record (MAR) for 1 (Resident #30) of 5 sampled residents reviewed for unnecessary medications. Findings included: Resident # 30 was admitted to the facility on 10/29/13 with diagnoses including constipation. The annual Minimum Data Set (MDS) assessment dated 10/5/15 indicated that Resident #30 had severe cognitive impairment. The physician's orders were reviewed. On 3/2/15, Resident #30 had an order for Senna Plus (a laxative/stool softener) two tablets by mouth at bedtime for constipation. Review of the resident's MARs for August, September and October, 2015 revealed that Senna Plus was transcribed as Senna Lax (a laxative) to the MAR. On 10/21/15 at 2:20 PM, administrative staff #1 was interviewed. After reviewing the records, administrative staff #1 indicated that Nurse #1 incorrectly transcribed the Senna Plus to the MAR. She added that the incorrect transcription started in March, 2015 when the order was written. Administrative staff #1 confirmed that Resident #30 incorrectly received Senna Laxative instead of Senna Plus from 03/02/15 to 10/20/15. On 10/21/15 at 2:40 PM, Nurse #1 was interviewed. She acknowledged that she made a	F 281	1. Physician notified of medication transcription error and ordered to continue with current order for Senna for Resident #30 10/21/2015. Director of Nursing re-educated Nurse #1 on process for medication order transcription and action of Senna versus Senna Plus on 10/21/2015. 2. Director of Nursing, Assistant Director of Nursing and designated licensed nurses will complete audit of current residents physician orders from 01/01/2015 to 11/13/2015. The audit of physician orders was completed on November 13, 2015. 3. Nurse Practice Educator (NPE) will re-educate licensed nurses, including weekend and prn licensed nurses by 11/18/2015, concerning Monthly Physician/Mid-level Provider Order Review and Transcription of Orders. Licensed nurses (including weekend and prn) will complete return demonstration of transcribing and correctly entering physician order into center training site by 11/18/2015. Director of Nursing, Assistant Director of Nursing and/or RN Supervisor will conduct checks of physician orders received prior day, will be review and	

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F 281	Continued From page 4 mistake in transcribing the Senna Plus to the resident's March 2015 MAR.	F 281	reconcile with handwritten orders (if applicable) and will check Medication Administration Record (MAR)/Treatment Administration Record (TAR) for transcription accuracy in Clinical Standup 5 days/week indefinitely. 4. Director of Nursing will report the findings of audits to the Performance Improvement meeting monthly times 3 months then quarterly.	
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff and resident interview, the facility failed to closely monitor the skin and protect the skin from rubbing against a knee brace which resulted in the development of an unstageable pressure ulcer to the right medial knee for 1 (Resident #25) of 2 sampled residents with pressure ulcers. Findings included: Resident #25 was re-admitted to the facility on 9/7/15 status post below the knee amputation of	F 314	1. Residents #25 is currently receiving treatment for right medial knee wound as follows: Cleanse right medial knee wound with DWC, apply Aquacel to wound bed, then apply foam dressing and wrap with Kerlix q day until healed. Physician and family are aware. Resident #25 wound is improving with treatment. 2. Director of Nursing and Assistant Director of Nursing completed an audit of	11/18/15

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F 314	Continued From page 5 the right leg. The quarterly Minimum Data Set (MDS) assessment dated 10/5/15 indicated that Resident #25's cognition was intact and she had an unstageable pressure ulcer. The nursing admission assessment dated 9/7/15 indicated that the resident was admitted with skin impairment to the right stump. The resident's nurse's notes from 9/7/15 through 9/18/15 were reviewed. There were no documentation that Resident #25 was wearing a brace to her right leg or the skin surrounding the brace was closely monitored for skin breakdown except for the notes dated 9/15/15. The notes dated 9/15/15 at 11:00 AM indicated that an "area was noted to the right inner knee and it appeared to be from the resident's stump brace." The resident's weekly skin checks were reviewed. The weekly skin checks were conducted on the 7: 00 AM to 3:00 PM shift every Monday. The skin checks completed on 9/14/15, 9/21/15 and 9/28/15 indicated that the resident had previously noted skin injury/wound. The checks did not indicate that the resident had a new skin breakdown. The resident's weekly skin integrity reports were reviewed. The report indicated that on 9/18/15, Resident #25 was noted to have an unstageable pressure ulcer on the right medial knee. The ulcer had 90% slough and 10% granulation measuring 1.5 centimeter (cm) x (by) 5.3 cm. On 10/16/15, the report indicated that the ulcer on the resident's right medial knee had 80% slough and 20% granulation measuring 1 cm x 5 cm. On 10/14/15, there was a physician's order to clean the resident's right medial knee with a	F 314	residents who have brace(s), splint(s), immobilizer(s) and prosthetic devices on 10/22/2015. Physician orders were obtained for those residents who have adaptive equipment and their Treatment Administration Records were updated on 11/12/2015. Director of Nursing completed full body assessments on those residents identified as having braces, splints, immobilizers and/or prosthetic devices on 10/23/2015. No new skin integrity concerns were identified. 3. Physician orders were obtained for residents that use braces, splints, immobilizers and prosthetic devices which include when to be applied and removed. The physician□s orders also include inspection of skin integrity prior to applying the device. The licensed nurse will document the application, skin inspection and remove on the treatment record according to the physician□s order. Director of Nursing, Assistant Director of Nursing, Nurse Practice Educator and RN Supervisors will re-educate licensed nurses (including weekend and prn licensed nurses), certified nursing assistants (including weekend and prn nursing assistants) and therapy staff on policy and procedure for braces, splints, immobilizers and prosthetic devices. The Director of Nursing, Assistant of Nursing and RN Supervisor will audit Treatment Administration Record that is completed by the medication nurse, as well as assess those residents who have adaptive equipment 2 x per week x 4	

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F 314	Continued From page 6 wound cleanser, apply calcium alginate to the wound bed, cover with foam, wrap with kerlix and to change it daily and as needed. On 10/20/15 at 2:15 PM, interview with administrative staff #1 was conducted. She stated that Resident #25 had developed an unstageable pressure ulcer on the right medial knee. She indicated that the pressure ulcer was from the resident's knee brace. Administrative staff #1 stated that Resident #25 was re-admitted to the facility on 9/7/15 with a brace to her right leg to support the stump. On 10/21/15 at 9:40 AM, observation of a dressing change to Resident #25's right knee was conducted. Nurse #1 performed the dressing change. The pressure ulcer on the resident's right medial knee had slough in the center. The ulcer was cleaned with wound cleaner, calcium alginate was applied to the wound bed, covered with a foam dressing and secured with kerlix. On 10/21/15 at 9:50 AM, Nurse #1 was interviewed. She indicated that Resident #25 was re-admitted on 9/7/15 status post below the knee amputation of the right leg. The resident was admitted with a brace on her right leg to support the stump. The resident had to wear the brace at all times. She added that she noticed the redness on the resident's right knee and she thought that the dressing to the stump was too tight that caused the redness. Later on, she realized that the redness was from the resident's knee brace rubbing against the skin so she removed the brace from the resident's leg. Nurse #1 described the brace as a hard plastic material. On 10/22/15 at 9:50 AM, Resident #25 was	F 314	weeks then 1 x per week x 2 months. The audit of splints, immobilizers, braces and prosthetic devices will include: the device is applied/removed as ordered and skin integrity is monitored. 4. Director of Nursing will report the findings of audits to the Performance Improvement meeting monthly times 3 months then quarterly.	

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F 314	Continued From page 7 interviewed. She stated that her knee brace was made of a clear white, hard plastic material. She added that the end of the brace was rubbing the back of her knee but she didn't know that there was an open area at the back of her knee. On 10/22/15 at 10:15 AM, administrative staff #1 was interviewed. She stated that the skin breakdown that Resident #25 experienced on her knee from the use of the knee brace could have been avoided. She indicated that when the resident was admitted, the nurse should have called the physician and obtained an order for the use of the knee brace and the instruction on how and when to apply the brace. She also indicated the application and the monitoring of the resident's skin should have been done and documented in the resident's medical records. On 10/22/15 at 10:35 AM, the resident's knee brace was observed. The brace was white and made of a hard plastic material. The front part of the brace that was protecting the resident's stump was padded but the rest of the brace had no padding on it. On 10/22/15 at 10:50 AM, Nurse #1 was interviewed. She stated that a doctor's order should have been obtained for Resident #25 on admission for the use of the brace including the instruction on how and when to apply it. She also stated that the application and observation of the resident's skin to prevent the skin from breakdown should have been completed by staff and documented in the resident's medical records.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		11/18/15

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F 323	Continued From page 8 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. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, staff interviews and observations, the facility failed to follow the policy on smoking for one of three residents (Resident #133) reviewed for smoking. The findings included: The Smoking Policy revised 4/1/15 stated " Patients will not be allowed to maintain their own lighter fluid or matches. " The Siler City Center Smoking List included Resident #133. Resident #133 was admitted on 3/14/15 with multiple diagnoses including dementia. A review of the annual Minimum Data Set dated 7/13/15 revealed the resident was assessed as being cognitively intact. The resident was assessed with current tobacco use. The Plan of Care dated 10/8/15 indicated the resident may smoke independently per smoking assessment. The interventions included the resident will dispose of smoking materials in a safe manner.	F 323	1. Resident #133 voluntary acknowledged to Administrator he would like to go to another center that would allow him to keep not only his cigarettes but his lighter too. Center has found alternate placement for resident. 2. Administrator, Director of Nursing and Social Work interviewed current smokers to ensure that they did not have material for lighting cigarettes in their possession. No resident had lighting material in their possession on 10/26/2015. Director of Nursing and/or Licensed Nurse reassessed and updated each resident Smoking Assessment on 11/05/2015. Administrator and both Social Workers held a meeting on 11/06/2015 with residents who currently smoke. Administrator discussed and reviewed the centers Smoking Policy with emphasis on lighting materials and where they are to be stored. Each resident received a copy of the Smoking Policy and signed a Smoking Acknowledgement Form. 3. Nurse Practice Educator and/or RN	

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F 323	Continued From page 9 The Smoking Evaluation dated 10/17/15 indicated that independent smoking was allowed for Resident #133. An interview was conducted on 10/20/15 at 11:01 AM with Resident #133. He stated that he has smoked in the courtyard. He stated that he kept his cigarettes in his bedside table. He stated that he had his own lighter and he lit his own cigarettes. An observation was made on 10/20/15 at 11:01 AM of Resident #133 removing a lighter from his pant pocket and placing the lighter back into the pocket. An interview was conducted on 10/22/15 at 10:17 AM with Resident #133. He stated that he has smoked about four times a day. He stated that he has kept his lighter on his bedside table at night. An observation was made on 10/22/15 at 10:17 AM of Resident #133 removing a lighter from his pant pocket and placing the lighter back into the pocket. An interview was conducted with Administrative Staff #1 on 10/22/15 at 10:38AM. She stated she was not aware that Resident #133 kept his own lighter to use for smoking. She stated she thought the resident ' s lighter was kept in a locked drawer at the nurses ' station when not in use. Administrative Staff #1 stated the nurse assigned to 400 Hall was responsible for retrieving the resident ' s lighter upon request and securing it in a locked drawer after use. An interview was conducted with Nurse #1 on 10/22/15 at 12:58PM. The nurse stated she was	F 323	Supervisors will re-educate department heads, licensed nurses (including weekend and prn licensed nurses), certified nursing assistants (including weekend and prn nursing assistants), dietary staff (including weekend and prn), Housekeeping and Laundry staff (including weekend and prn) and therapy staff on the centers Smoking Policy. Social Workers or RN Supervisors will complete random interviews with residents that smoke to ensure they do not have lighting material in their possession. The interviews will be documented in the progress notes on alternating shifts 6 x weekly including weekends for 1 month then 3 x□s weekly for 2 months and quarterly thereafter. 4. Administrator and/or Social Work will report the findings of random spot checks of smoking to the Performance Improvement meeting monthly times 3 months then quarterly.	

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F 323	Continued From page 10 assigned to 400 Hall where Resident #133 resided. Nurse #1 stated she was aware that the resident was a smoker. She stated she was not aware that the resident kept his lighter in his possession. She stated that Resident #133 had not asked her to retrieve his lighter from the nurses ' station.	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 influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures	F 334		11/18/15

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F 334	Continued From page 11 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. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to obtain informed consent when	F 334	1. Residents #4, #41 and #98 responsible parties were contacted regarding the	

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F 334	Continued From page 12 offering the influenza vaccine for the 2014 - 2015 influenza vaccine season for 3 of 5 Residents (Resident #98, #41 and #41). Findings included: 1. Resident #98 was admitted 6/1/11. The Quarterly Minimum Data Set (MDS) Assessment dated 9/22/15 revealed Resident #98 was cognitively impaired. Review of the Influenza Immunization Informed Consent form revealed it was signed by a family member of Resident #98 on 9/5/13. The section that read " hereby give the center permission to administer an influenza vaccination annually, in the fall " was checked. An Influenza Immunization Informed Consent form for the 2014 - 2015 influenza immunization season could not be located within the medical record. Review of the Influenza Vaccine Administration Record revealed Resident #98 was administered the vaccine on 10/3/14 for the 2014 - 2015 influenza vaccination season. On 10/22/15 at 12:05 PM interview with Nurse #4 revealed that she had just taken over the Immunization Coordinator role. She stated that she had been unaware that once a consent for Influenza Vaccine had been obtained in a given year that it still needed to be obtained in subsequent years, even thou the facility form indicated an ongoing annual consent. She added that residents who could speak for themselves could be asked for their informed consent at the time of administration but acknowledged that cognitively intact residents could not. In addition, Nurse #4 stated she had been looking through medical records to locate documentation of informed consent and had not been able to find any other documentation other than the above. Nurse #4 acknowledged that there was no documentation to show that prior to Resident #98 receiving the influenza vaccine in 2014 that the	F 334	Influenza vaccine and education on 11/06/15 by Nurse Practice Educator. Administrator and Director of Nursing re-educated Nurse #4 on Influenza Policy and Procedures on 11/06/2015. 2. Nurse Practice Educator (NPE) completed audit of resident consent for Influenza Vaccine on 11/06/2015. Residents and/or responsible parties that had refused the vaccine in the past were notified and flu vaccine information was related to them. Residents and/or responsible parties that consented to the vaccine were provided the Vaccine Information Sheet (VIS). 110 residents and/or responsible parties consented to the vaccine and 11 refused the vaccine. 3. Nurse Practice Educator and/or RN Supervisors will re-educate licensed nurses including weekend and prn licensed nurses, on the centers Influenza Policy and procedures, obtaining consent and providing education as well as monitoring before and after vaccine. Effective 11/04/2015, any newly admitted resident will be asked if they wish to receive influenza vaccine or decline the vaccine. Vaccine Information Sheet will be provided at that time. Current residents and responsible parties received a copy of the Influenza Information Statement (VIS). A copy of the VIS was mailed to the responsible parties on 11/06/15. Nurse Practice Educator to audit new admits weekly x 4 weeks then each month x 2 months and quarterly thereafter.	

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F 334	Continued From page 13 family/Responsible party was asked to consent for that year, or that the family/Responsible Party, or other residents, received the appropriate Vaccine Information Statement to make an informed choice. 2. Resident #4 was admitted 2/23/10. The annual Minimum Data Set (MDS) Assessment dated 9/8/15 revealed Resident #4 was cognitively impaired. Review of the Influenza Immunization Informed Consent form revealed it was signed by a family member of Resident #4 on 9/16/13. The section that read " hereby give the center permission to administer an influenza vaccination annually, in the fall " was checked. An Influenza Immunization Informed Consent form for the 2014 - 2015 influenza immunization season could not be located within the medical record. Review of the Influenza Vaccine Administration Record revealed Resident #4 was administered the vaccine on 10/3/14 for the 2014 - 2015 influenza vaccination season. On 10/22/15 at 12:05 PM interview with Nurse #4 revealed that she had just taken over the Immunization Coordinator role. She stated that she had been unaware that once a consent for Influenza Vaccine had been obtained in a given year that it still needed to be obtained in subsequent years, even thou the facility form indicated an ongoing annual consent. She added that residents who could speak for themselves could be asked for their informed consent at the time of administration but acknowledged that cognitively intact residents could not. In addition, Nurse #4 stated she had been looking through medical records to locate documentation of informed consent and had not been able to find any other documentation other than the above. Nurse #4 acknowledged that there was no documentation to show that prior to Resident #4	F 334	4. Nurse Practice Educator will report the findings of audits of how many residents received the vaccine and how many declined to the Performance Improvement meeting monthly times 3 months then quarterly.	

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F 334	Continued From page 14	F 334		

receiving the influenza vaccine in 2014 that the family/Responsible party was asked to consent for that year, or that the family/Responsible Party, or other residents, received the appropriate Vaccine Information Statement to make an informed choice.
3. Resident #41 was readmitted 12/27/14. The Quarterly Minimum Data Set (MDS) revealed Resident #41 was moderately cognitively impaired.
Review of the Influenza Immunization Informed Consent form revealed it was signed by a family member of Resident #41 on 8/27/13. The section that read " hereby give the center permission to administer an influenza vaccination annually, in the fall " was checked. An Influenza Immunization Informed Consent form for the 2014 - 2015 influenza immunization season could not be located within the medical record.
Review of the Influenza Vaccine Administration Record revealed Resident #41 was administered the vaccine on 10/21/14 for the 2014 - 2015 influenza vaccination season.
On 10/22/15 at 12:05 PM interview with Nurse #4 revealed that she had just taken over the Immunization Coordinator role. She stated that she had been unaware that once a consent for Influenza Vaccine had been obtained in a given year that it still needed to be obtained in subsequent years, even thou the facility form indicated an ongoing annual consent. She added that residents who could speak for themselves could be asked for their informed consent at the time of administration but acknowledged that cognitively intact residents could not. In addition, Nurse #4 stated she had been looking through medical records to locate documentation of informed consent and had not been able to find any other documentation other than the above.

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F 334	Continued From page 15 Nurse #4 acknowledged that there was no documentation to show that prior to Resident #41 receiving the influenza vaccine in 2014 that the family/Responsible party was asked to consent for that year, or that Resident #41, the family/Responsible Party, or other residents, received the appropriate Vaccine Information Statement to make an informed choice.	F 334		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced	F 520		11/18/15

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F 520	Continued From page 16 by: Based on record review, observations, resident interviews, and staff interviews the facility ' s Quality Assessment and Assurance (QAA) Committee failed to implement, monitor and revise as needed the action plan developed for the 10/30/14 recertification survey in order to achieve and sustain compliance in the areas of accuracy of assessment (F278) and accidents (F323) . These deficiencies were cited again on the current recertification survey of 10/22/15. The findings included: This tag is cross referenced to: F278 - Accuracy of assessment: Based on record review and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) assessment for pressure ulcer (Resident #25) and for hydration (Resident #42) for 2 of 23 sampled residents reviewed. During the recertification survey of 10/30/14 the facility was cited F278 for failing to accurately code the MDS to reflect Level II Preadmission Screening and Resident Review determination. F323 - Accidents: Based on record review, resident interview, staff interviews, and observations, the facility failed to follow the policy on smoking for 1 of 3 residents (Resident #133) reviewed for smoking. During the recertification survey of 10/30/14 the facility was cited F323 for failing to identify potentially hazardous conditions of pipe access portals. On 10/22/15 at 12:35PM an interview with the Administrator was conducted. She stated that she is the head of the facility ' s QAA Committee. She stated that the QAA Committee consisted of the medical director, the pharmacist and all department heads, including the director of nursing and the assistant director of nursing. The	F 520	1. Modifications were made to the Minimum Data Set for Resident #42 and Resident #25 on 10/21/2015. The modification for Resident #42 included changing the dehydration status from yes to no and the modification for Resident #25 was changed from present on admission to in-house acquired. Resident #133 acknowledged to Administrator he would like to go to another center that would allow him to keep not only his cigarettes but his lighter too. Center has found alternate placement for resident. 2. Director of Nursing, Assistant Director of Nursing and Clinical Reimbursement Coordinator completed audit on 11/10/2015 of Minimum Data Set for those residents who were coded for dehydration and pressure ulcers. Administrator, Director of Nursing and Social Work interviewed current smokers to ensure that they did not have material for lighting cigarettes in their possession. No resident had lighting material in their possession on 10/26/2015. Director of Nursing and/or Licensed Nurse reassessed and updated each resident Smoking Assessment on 11/05/2015. Administrator and both Social Workers held a meeting on 11/06/2015 with residents who currently smoke. Administrator discussed and reviewed the centers Smoking Policy with emphasis on lighting materials and where they are to be stored. Each resident received a copy of the Smoking Policy and signed a Smoking Acknowledgement Form.	

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F 520	Continued From page 17 committee had met monthly without the pharmacist and quarterly with all participants. The Administrator indicated that she was aware that accuracy of assessments was a repeat deficiency from the previous recertification survey. She stated that the action plan that was put into place from the previous recertification survey was monitored by herself, the Director of Nursing (DON), and Administrative Staff #3. She stated that Administrative Staff #3 was responsible for the coding the MDS. She stated she believed the accuracy errors that resulted from miscoding was caused by human error of Administrative Staff #3. The Administrator stated that to her knowledge no one audited Administrative Staff #3 for accuracy. The Administrator also indicated that she was aware that accidents was a repeat deficiency from the previous recertification survey. She stated that the action plan that was put into place from the previous recertification survey was monitored by herself and by housekeeping staff. She indicated that residents ' lighters were to be kept locked in the nurse ' s station when not in use. She revealed that she did not know that Resident #133 kept his own lighter.	F 520	Social Work and Clinical Reimbursement Coordinator completed an audit of those residents requiring a Level II PASARR on 11/09/2015 to ensure their individual Minimum Data Sets are coded correctly. All residents were found to be coded correctly. Maintenance Director completed an audit of pipe access portals on each hall on 11/12/2015 to ensure that all access portals are at the same level as the surrounding flooring and do not pose a hazard for residents, as well as employees and visitors. 3. Administrator will provide re-education to the Quality Improvement Members including Medical Director, Director of Nursing, Assistant Director of Nursing, Clinical Reimbursement Coordinator, Recreation Director, Social Worker, Register Dietitian, Food Service Director, Housekeeping Supervisor and Medical Records on 11/13/2015. Regional Clinical Reimbursement Coordinator will provide re-education to Clinical Reimbursement Coordinator on MDS accuracy 11/16/2015. The Interdisciplinary Team, including Director of Nursing, Clinical Reimbursement Coordinator, Recreation Director, Social Worker and Register Dietitian review the entire Minimum Data Set for accuracy prior to transmission each week on 100% of residents x 4 weeks then 50% of residents x 4 weeks then 25% of residents x 4 weeks and 10% of residents quarterly thereafter. Nurse Practice Educator and/or RN Supervisors will re-educate department heads, licensed nurses (including weekend and	

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F 520	Continued From page 18	F 520	prn licensed nurses), certified nursing assistants (including weekend and prn nursing assistants), dietary staff (including weekend and prn), Housekeeping and Laundry staff (including weekend and prn) and therapy staff on the centers Smoking Policy by 11/18/2015. Social Workers and/or RN Supervisors will complete random interviews with residents that smoke to ensure they do not have lighting material in their possession. The interviews will be documented in the progress notes on alternating shifts 6 x weekly including weekends for 1 month then 3 x□s weekly for 2 months and quarterly thereafter. Maintenance Director, Maintenance Assistant and/or Housekeeping Supervisor will audit pipe access portals weekly x 2 months then monthly x 3 months and quarterly thereafter. RN Supervisor will make Environmental Rounds to identify any fall and/or environmental hazards daily x 4 weeks, 2 times weekly x 4 weeks, weekly x 2 months, then quarterly. Any hazards identified will be addressed immediately and reviewed at stand-up 5 days/week. All incidents/accidents are reviewed at clinical stand-up 5 days/week. 4. Clinical Reimbursement Coordinator, Director of Nursing and Maintenance Director will report the findings of audits to the Performance Improvement meeting monthly times 6 months then quarterly thereafter.	