STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345343	A. BUILDING _____ B. WING _____	C 12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO	1700 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534

(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 000	INITIAL COMMENTS There were no deficiencies cited as a result of the complaint investigation survey of 12/10/15. Event ID CGNY11.	F 000		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete a significant change in status assessment for one of one sampled residents who was discharged from Hospice for failure to decline (Resident #164). The Findings Include: Resident #164 was admitted to the facility on 10/27/14. Cumulative diagnoses include: right artificial hip joint, mood affective disorder, insomnia, psychosis, major depression, Alzheimer ' s disease, hypertension, and	F 274	A significant change was completed for resident #164 on 12/14/15 with an ARD of 12/10/15 by the MDS Director . The facility residents identified as receiving hospice services were reviewed by the MDS director on 12/9/15. The review was conducted to ensure that residents who require a significant change MDS have had one completed. The facility interdisciplinary team have received re-education regarding the	1/7/16

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

Electronically Signed | 12/31/2015

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F 274	Continued From page 1 dysphagia. A Minimum Data Set (MDS) assessment dated 10/28/15 indicated Resident #164 was severely impaired in cognition. Extensive assistance was needed for bed mobility, locomotion, dressing, toilet use, bathing, eating, transfer, and personal hygiene. Resident #164 was noted to be always incontinent of bowel and bladder. Resident #164 ' s prognosis revealed he had a condition or chronic disease that may result in life expectancy of less than 6 months was checked yes. Resident #164 ' s Hospice (IDG) Comprehensive Assessment and Plan of Care Update Report dated 11/4/15 revealed diagnoses, Alzheimer ' s, cerebrovascular disease, hypertension, and Bipolar disorder. Resident #164 was discharged from Hospice on 10/23/15 due to no decline in condition. On 12/10/15 at 9:20 AM, Minimum Data Set (MDS) nurse #1 stated she was not notified until yesterday that resident #164 was no longer on Hospice, and that the Hospice nurse failed to let her know that resident #164 was discharged from Hospice care on 10/23/15. She said there should have been a MDS significant change assessment completed within 14 days from discharge from Hospice on 10/23/15, and it was an oversight. Staff interview with the ADON on 12/10/15 at 9:45: AM confirmed that there should have been a significant change MDS update and there wasn ' t for Resident #164. She said the Hospice nurse failed to let the facility know of the resident ' s discontinuation from Hospice Care due to resident ' s failure to decline.	F 274	communication process related to a facility resident being placed on hospice or discharged from hospice on 12/9/15 by social worker and MDS director. An audit of the facility residents placed on or discharged from hospice services will be completed by the MDS director and Social worker weekly x4 and monthly times two, to assure compliance. Findings will be corrected as warranted. The MDS director will report findings of weekly audits to the facility Quality Assurance Performance Improvement (QAPI) Committee times four weeks and monthly times two. The committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.	

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F 274	Continued From page 2 Staff interview with the DON on 12/10/15 at 9:55 AM revealed that Resident #164 should have had a MDS significant change assessment within 14 days of being discharged from Hospice Care Services due to resident ' s failure to decline.	F 274		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET 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 observation, record review and staff and resident interviews the facility failed to follow fluid restriction orders for 1 of 1 (Resident # 50) sampled residents. Findings included: Resident #50 was admitted to the facility on 10/30/13 with cumulative diagnoses of End Stage Renal Disease (ESRD), diabetes, and muscle weakness. Resident #50's Quarterly Minimum Data Set (MDS) dated 11/09/15 revealed Resident #50 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 13. Review of the December 2015 Physician Orders showed a 1500 ml (milliliter)/24 hours fluid restriction was ordered for Resident #50. Review of the December 2015 Medication Administration Record (MAR) showed Resident #50 had scheduled medications for 6:00 AM, 9:00 AM, 12:00 PM, 5:00 PM, and 9:00 PM. As needed medications were also ordered. Review of a representative sample of meal cards dated 12/05/15, 12/07/15, and 12/09/15 for Resident #50 revealed the kitchen sent a daily fluid total of 1680 ml on Resident 50's meal trays.	F 281	Resident #50's physician orders were reviewed on 12/9/15 by nurse unit manager. Clarification orders were obtained by attending physician to reflect the portion of the total volume of fluids to be provided by both dietary and nursing departments. An audit was completed of facility residents who were identified on a fluid restriction on 12/10/15 by nurse unit managers. Clarification orders were obtained as needed to ensure resident orders reflected the portion of the total volume of fluids to be provided by both dietary and nursing departments. The medication record for each resident was updated to reflect the planned volume allowed per nursing department each shift on 12/10/15 by nurse unit managers. Facility direct care staff were re-educated by staff development coordinator on facility expectations related	1/7/16

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F 281	Continued From page 3 In an interview on 12/08/15 at 3:17 PM Resident #50 stated she was on a fluid restriction and followed it carefully. She indicated she only drank the fluids the facility gave her. Resident #50 indicated she got fluids on her meal trays, with her snacks, and each time she received medications. Resident #50 stated she did not receive a water pitcher in her room. In an observation on 12/09/15 at 12:16 PM Resident #50 received her lunch tray. The tray contained a 240 ml cup of tea and a 240 ml cup of water. The meal card for Resident #50 listed Milk 4 oz (ounce) and "give tea and water." The meal card did not indicate that Resident #50 was on a fluid restriction. The staff member who brought in the tray stated she would bring back Resident #50's milk as it was missing from the tray. In an interview on 12/09/15 at 12:21 PM Nurse #10 indicated she knew Resident #50 was on a fluid restriction. She stated she did not provide a specific amount of fluids to Resident #50 during her shift and did not know how much fluid was sent by the dietary department. She stated the amount of fluids provided by the nursing staff was not being tracked separately from dietary. In an interview on 12/09/15 at 2:55 PM the Dietary Manager stated the Nursing department was supposed to coordinate with him the amounts of fluid the dietary department could send so fluid restrictions were not exceeded. He indicated this had not been done. The Dietary Manager stated the meal cards did not show which residents were on fluid restrictions. In an interview on 12/09/15 at 5:42 PM Nurse #11 stated she provided fluids to Resident #50 based on what was given on the previous shift. She indicated that since the amounts were not recorded she really did not know how much fluids	F 281	to documentation of resident fluid intake and importance of maintaining resident fluid restriction orders to begin on 1/2/16 and completed by 1/7/16. Dietary staff were educated by the dietary manager on the importance of following prescribed fluid restrictions on 12/10/15 and completed 12/14/15. Newly hired direct care staff or dietary staff will receive the education during orientation. Any staff that is required to receive re-education will not work until education is complete. The DON or designee will complete weekly audits of residents with fluid restriction orders to ensure nursing compliance with fluid intake and documentation weekly times four and monthly times two. A tray accuracy audit will be conducted by the dietary manager three times per week at random meals times four weeks then monthly times two to verify order restrictions are being followed by the dietary staff. The DON and Dietary Manager or designee will report findings of weekly audits to the facility QAPI committee weekly times four and monthly times two. The committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.	

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F 281	Continued From page 4 she could give. Nurse #11 pointed to the plastic drinking cups on the medication cart and stated she usually gave Resident #50 half a cup of water (approximately 120 ml) each time she provided medications. In an interview on 12/10/15 at 10:15 AM the Dietary Manager stated when the meal card listed "give tea and water" 240 ml of each was provided. In an interview on 12/10/15 at 10:55 AM the Director of Nursing (DON) stated there were no fluid intake flow sheets available for review because nursing was not tracking what they specifically provided to Resident #50. She indicated she expected the nursing staff to track the amounts of fluids they provided to residents on fluid restrictions. The DON indicated she expected the Dietary Manager and the Registered Dietician to monitor what was provided through the dietary department so fluid restrictions were not exceeded. She indicated she expected physician orders to be followed.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to implement interventions care planned for 2 of 14 residents (Resident#5 and Resident #59) whose care plans were reviewed in Stage 2 of the annual	F 282	Resident #5's physician orders were reviewed to ensure resident's labs were being completed as ordered per the care plan on 12/10/15 by the Assistant Director of Nursing.	1/7/16

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F 282	Continued From page 5 recertification survey. The Findings Included: 1. Resident #5 was admitted to the facility on 3/12/14 with a diagnosis history that included diabetes mellitus type II, hypertension, hyperlipidemia, chronic obstructive pulmonary disease (COPD), history of pulmonary embolism, and heart failure. A review of physician orders and medication administration records (MARs) for Resident #5 from July 2015 through November 2015 revealed that the resident was receiving an anticoagulant medication, Coumadin, and was to have labs done each week on Monday to monitor the therapeutic effects of this medication per physician orders. A review of labs between July 2015 and November 2015 showed that there were no labs drawn to monitor the Prothrombin time/International Normalization Ratio (PT/INR) in the months of July and August 2015. A review of Resident #5's care plan, most recently updated on 12/9/15, revealed that the resident had a potential for medication toxicity due to associated diagnoses or treatment regimen with a goal of no evidence of medication toxicity through the next 90 days. Interventions included administering medication per order and monitoring labs as ordered. Interview with the Assistant Director of Nursing (ADON) on 12/10/15 at 3:57 PM revealed the facility obtained PT/INR according to physician orders. The ADON indicated she could not locate a lab in which Resident #5 had PR/INR levels tested in the months of July and August 2015 and reported that the facility had discovered the missed labs on 9/14/15 and completed a medication variance report and reported the	F 282	A nutritional assessment was completed for resident #59 on 12/10/15 with appropriate recommendations made by the Registered Dietician. The attending physician was notified of recommendation and orders were obtained 12/10/15. The resident's care plan was also reviewed and updated on 12/10/15. A facility audit will be conducted on residents receiving anticoagulant medication requiring lab monitoring to ensure labs are monitored as ordered on 1/5/16 by nurse unit managers. Facility audit of current resident's weights for the last 30 days was conducted by the RD on 12/21/15 to ensure significant weight changes have been addressed and recommendations implemented. A review of care plans for residents with significant weight changes in the last 30 days will be done to ensure that each plan of care reflects the residents' current nutritional interventions. A review of care plans for residents receiving anticoagulant therapy requiring lab monitoring will be done to ensure that interventions care planned for are being implemented as ordered. The Dietary Manager was educated by the Divisional Clinical Manager on the usage of the RD referral form on 12/11/15. Licensed nurses were educated by nurse unit managers and/or staff development	

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F 282	Continued From page 6 missed labs to the doctor. The ADON also stated that they resumed weekly PT/INR labs for Resident #5 according to the physician orders starting on 9/14/15. In a follow-up interview with the ADON at 4:10 pm on 12/10/15, she stated that there was no dedicated nurse in charge of monitoring labs at the time the labs for Resident #5 were missed and she was not sure who would have been in charge of writing the orders to draw the labs, but it may have been the unit manager at the time, who was no longer with the facility. The ADON reported that she understood the importance of completing the labs as ordered and that Resident #5 might have had a negative outcome, such as bleeding out, as a result of not monitoring her PT/INR levels while taking Coumadin. She stated that there was still no dedicated nurse assigned the task of ensuring labs were done as ordered, but the facility was in the process of putting a system in place with the new administrative nursing staff and it would be her expectation that all labs would be completed as ordered per the care plan. 2. Resident #59 was admitted to the facility Resident #59 was admitted to the facility on 4/23/15 with a diagnosis history that included epilepsy, essential hypertension, muscle weakness, severe intellectual disabilities, and dysphagia. A review of the quarterly nutrition/dietary note, dated 11/22/15, revealed that Resident #59 had a weight loss greater than 5% in 30 days, greater than 7.5% in 90 days, and greater than 10% in 180 days and a BMI under 22 and the certified dietary manager (CDM) was to refer the resident to the RD.	F 282	coordinator beginning on 1/2/16 on the usage of the RD referral form and the importance of implementing care planned interventions for residents including monitoring labs as ordered by the physician. Newly hired staff will receive education during orientation. The DON/designee will perform weekly audits times four on a minimum of three residents care planned for anticoagulant therapy requiring lab monitoring to ensure the resident's care planned interventions are being implemented as ordered. The Regional/Divisional Dietician and or designee will review three charts weekly times four to ensure that significant weight changes have been addressed with recommendations implemented as appropriate. The DON will report findings of weekly audits to the facility QAPI committee weekly times four and monthly times two. The committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.	

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F 282	Continued From page 7	F 282		

The most recent Minimum Data Set (MDS), dated 11/24/15 indicted that resident #59 was cognitively impaired, required extensive assistance with all activities of daily living (ADLs) and had a noted weight loss from the previous assessment of 5 % or more in 30 days, 7.5% or more in 90 days, and/or 10% or more in 180 days.

A review of Resident #59's care plan, dated 11/25/15, revealed that the resident was care planned for weight loss and that the goal was for weight to stabilize each month through the next review which would take place in 90 days. Interventions included providing resident #59 supplements as ordered and RD referral.

During the initial tour on 12/07/15, Resident #59 was observed eating breakfast, but there were no supplements provided to the resident at that time.

In an interview with the RD at 12:07 PM on 12/10/15, he stated that Resident #59 should have showed up on a report that he printed out when he entered the building. He reported that he was at the facility earlier this week on 12/07/15 and would have viewed this resident's chart and started an intervention for weight loss had he received the referral.

At 12:15 PM on 12/10/15, the CDM stated that he did not keep a list of people he referred to the RD because it was usually done in passing or through a text. He reported that otherwise, if a resident had a significant weight loss that was captured on the MDS, the resident would show up on the report that would be given to the RD during his visit. He was not able to verify if he had referred

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F 282	Continued From page 8 Resident #59 or not because he did not keep a record of referrals. In a follow up interview with the RD at 12:32 PM on 12/10/15 he reported that not only had this resident not been referred to him after the weight loss, he had not seen her or reviewed her chart for an initial assessment after she was admitted in April of 2015. He reported that he was not sure how or why she slipped through the cracks and her assessment and the referral was missed, but that he would be sure to see her on his next visit and implement any necessary interventions for weight loss. At 2:54 PM on 12/10/15 both the ADON and DON reported that they were unaware that Resident #59 had not been assessed by the RD since admission and that a referral had not been made properly for triggered weight loss. They stated that they would expect that the RD would at least do an assessment/initial chart review for all new residents to determine a baseline as well as respond to any referrals received between assessments and as care planned.	F 282		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325		1/7/16

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F 325	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and Registered Dietician (RD) interviews, the facility failed to put interventions into place to address weight loss for 1 of 4 residents (Resident #59) reviewed for nutrition. The findings included: Resident #59 was admitted to the facility on 4/23/15 with a diagnosis history that included epilepsy, essential hypertension, muscle weakness, severe intellectual disabilities, and dysphagia. A review of the quarterly nutrition/dietary note, dated 11/22/15, revealed that Resident #59 had a weight loss greater than 5% in 30 days, greater than 7.5% in 90 days, and greater than 10% in 180 days and a body mass index (BMI) under 22 and the certified dietary manager (CDM) was to refer the resident to the RD. The most recent Minimum Data Set (MDS), dated 11/24/15 indicted that resident #59 was cognitively impaired, required extensive assistance with all activities of daily living (ADLs) and had a noted weight loss from the previous assessment of 5 % or more in 30 days, 7.5% or more in 90 days, and/or 10% or more in 180 days. A review of Resident #59's care plan, dated 11/25/15, revealed that the resident was care planned for weight loss and that the goal was for weight to stabilize each month through the next review which would take place in 90 days. Interventions included providing resident #59	F 325	The facility's registered dietician is no longer contracted with this facility. A nutritional assessment was completed for resident #59 on 12/10/15 with appropriate recommendations made by the RD. The resident's attending physician was contacted and orders received on 12/10/15. The resident's care plan was reviewed and updated on 12/10/15. A facility audit of current resident's weights for the last 30 days was conducted on 12/21/15 by the Registered Dietician to ensure weight changes have been addressed and recommendations implemented. A review of care plans for residents with significant weight changes in the last 30 days will be completed to ensure that each plan of care reflects the resident's current nutrition interventions. The Dietary Manager was educated by the Divisional Clinical Manager on the usage of the RD referral form on 12/11/15. Licensed nurses were educated by nurse unit managers and/or staff development coordinator beginning on 1/2/16 on the usage of the RD referral form. The Regional/Divisional Dietician and or designee will review three charts weekly times four and monthly times two to	

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F 325	Continued From page 10 supplements as ordered and RD referral. During the initial tour on 12/07/15, Resident #59 was observed eating breakfast, but there were no supplements provided to the resident at that time. In an interview with the RD at 12:07 PM on 12/10/15, he stated that Resident #59 should have showed up on a report that he printed out when he entered the building. He reported that he was at the facility earlier this week on 12/07/15 and would have viewed this resident's chart and started an intervention for weight loss had he received the referral. At 12:15 PM on 12/10/15, the CDM stated that he did not keep a list of people he referred to the RD because it was usually done in passing or through a text. He reported that otherwise, if a resident had a significant weight loss that was captured on the MDS, the resident would show up on the report that would be given to the RD during his visit. He was not able to verify if he had referred Resident #59 or not because he did not keep a record of referrals. In a follow up interview with the RD at 12:32 PM on 12/10/15 he reported that not only had this resident not been referred to him after the weight loss, he had not seen her or reviewed her chart for an initial assessment after she was admitted in April of 2015. He reported that he was not sure how or why she slipped through the cracks and her assessment and the referral was missed, but that he would be sure to see her on his next visit and implement any necessary interventions for weight loss. At 2:50 PM on 12/10/15 the DON stated it was	F 325	ensure that significant weight changes have been addressed with recommendations implemented as appropriate. The DON will report findings of weekly audits to the facility QAPI committee weekly times four and monthly times two. The committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.	

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F 325	Continued From page 11 her understanding that the RD visited the facility once a week or every couple of weeks and that nurse management or dietary was responsible for making necessary referrals to him for weight loss or any other interventions. She also stated that she was not aware of any tools or forms that would be used to make a formal referral. During the same interview the ADON stated that the RD visited the facility about every two weeks and that there was a RD referral form as well as a copy of weight that should be given to the RD. She also stated that the referral would be done by either nursing or dietary depending on the source of the assessment and that any recommendation that would come back from the RD would go through nursing so that an order could be written and a copy would be given to dietary. At 2:54 PM on 12/10/15 both the ADON and DON reported that they were unaware that Resident #59 had not been assessed by the RD since admission and that a referral had not been made properly for triggered weight loss. They stated that they would expect that the RD would at least do an assessment/initial chart review for all new residents to determine a baseline as well as respond to any referrals received between assessments.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose	F 329		1/7/16

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F 329	Continued From page 12 should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to obtain Prothrombin time (PT) and international normalized ratio (INR) labs for 1 of 5 residents (Resident #5) reviewed for unnecessary medications. The findings included: Resident #5 was admitted to the facility on 3/12/14 with a diagnosis history that included hypertension, anemia, pulmonary embolism, heart failure, and hyperlipidemia. Review of Resident #5's physician order sheets for the months of June 2015 through November 2015 revealed orders for Coumadin at varying doses and corresponding orders for labs to be drawn to check PT/INR levels each week on	F 329	Resident #5's physician was notified on 9/14/15 and a medication variance report was completed. Resident #5's medical record was reviewed on 12/10/15 to ensure resident's labs were being monitored as ordered by the Assistant Director of Nursing. All facility resident physician orders will be reviewed to identify residents with orders to obtain Prothrombin time (PT) and international normalized ratio (INR) labs on 1/5/16 by nursing unit managers. Licensed nurses will be educated by nurse unit manager and/or staff development coordinator beginning on 1/2/16 and completed by 1/7/16 on the	

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F 329	Continued From page 13 Monday. Review of Resident #5's labs from June 2015 through November 2015 revealed no labs in regards to PT/INR level testing for the use of Coumadin for the months of July and August 2015. Interview with the Assistant Director of Nursing (ADON) on 12/10/15 at 3:57 pm revealed the facility obtained PT/INR according to physician orders. The ADON indicated she could not locate a lab in which Resident #5 had PR/INR levels tested in the months of July and August 2015 and reported that the facility had discovered the missed labs on 9/14/15 and completed a medication variance report and reported the missed labs to the doctor. The ADON also stated that they resumed weekly PT/INR labs for Resident #5 according to the physician orders starting on 9/14/15. In a follow-up interview with the ADON at 4:10 pm on 12/10/15, she stated that there was no dedicated nurse in charge of monitoring labs at the time the labs for Resident #5 were missed and she was not sure who would have been in charge of writing the orders to draw the labs, but it may have been the unit manager at the time, who was no longer with the facility. The ADON reported that she understood the importance of completing the labs as ordered and that Resident #5 might have had a negative outcome, such as bleeding out, as a result of not monitoring her PT/INR levels while taking Coumadin. She stated that there was still no dedicated nurse assigned the task of ensuring labs were done as ordered, but the facility was in the process of putting a system in place with the new administrative	F 329	importance of obtaining resident labs as ordered to ensure adequate monitoring of the resident's drug regimen. Newly hired licensed nursing staff will receive this education during orientation. The facility nurse unit managers will log and track facility residents with orders for PT/INR labs daily to ensure resident labs are obtained as ordered. The Director of nursing (DON)/designee will complete weekly audit times four and monthly times two of nurse unit managers logs to ensure compliance with PT/INR lab monitoring. The DON will report findings to the facility Quality Improvement Committee weekly times four and monthly times two. The committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.	

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F 329	Continued From page 14 nursing staff and it would be her expectation that all labs would be completed as ordered.	F 329		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the temperature of a chilled salad made with mayonnaise at or below 41 degrees Fahrenheit during operation of the trayline. Findings included: At 5:37 PM on 12/09/15 there were 20 plates with potato salad on them, covered with plastic wrap, being stored on an open cart in the kitchen until they could be placed on resident meal trays. Plates with regular and puree potato salad were selected by the dietary manager (DM) who used a calibrated thermometer to check the temperature of both types of salad. The thermometer registered 60 degrees Fahrenheit when the regular potato salad was checked, and registered 62 degrees when the puree potato salad was checked. At this time the cook stated two more meal carts needed to be filled with the pre-plated potato salad.	F 371	The chilled salad with mayonnaise was discarded on 12/9/15 by dietary manager. Dietary staff was educated by the dietary manager on the importance of taking food temperatures on the tray line and documenting results in the temperature log. Dietary staff was also educated by the dietary manager on appropriate food temperature per ServSafe guidelines on 12/10/15. Newly hired dietary staff will receive the education during orientation. An audit of the food temperatures will be conducted weekly times four then monthly times two by the Dietary manager or designee three times a week at random meals to verify that both hot and cold temperatures are within acceptable parameters according to ServSafe	1/7/16

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F 371	Continued From page 15 At 5:46 PM the dietary manager (DM) stated he purchased containers of the commercially prepared potato salad which arrived in the facility on Tuesday, 12/08/15, and were stored in the walk-in refrigerator. The DM reported at about 2:15 PM on 12/09/15 the dietary staff finished placing the potato salad onto plates which were stored in an open cart placed in the walk-in refrigerator. He commented they remained there until the trayline operation began at about 5:00 PM on 12/09/15. The DM stated during the operation of the trayline he would expect the staff to take measures to keep the potato salad between 40 and 45 degrees Fahrenheit. He explained these measures included bringing out only a small number of plates from refrigeration at one time or keeping the potato salad on ice at the trayline where it could be dipped as needed. At 5:50 PM on 12/09/15 review of the ingredient list revealed the potato salad contained potatoes, mayonnaise, salad dressing, celery, mustard, spices, sugar, and pickle relish. At 5:52 PM on 12/09/15 review of trayline temperature sheets revealed there were no temperatures documented for hot or cold foods for the 12/09/15 supper meal. The DM reported a calibrated thermometer was supposed to be used to check the temperature of all hot and cold foods right before the trayline began operation so foods would be served in the correct temperature range. He commented if hot foods remained under 140 degrees Fahrenheit and cold foods remained above 40 degrees Fahrenheit for too long these foods posed a risk to resident health. At 9:10 AM on 12/10/15 the AM cook stated most	F 371	guidelines. The dietary manager will report findings of weekly audits to the facility QAPI committee weekly times four and monthly times two. The committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.	

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F 371	Continued From page 16 of the cold salads made with mayonnaise served by the facility were purchased from vendors. She reported she was trained to dish/plate up the cold salads the day before they were served, to store them in the walk-in refrigerator, and then bring out a small number of pre-plated salads at a time during trayline operation. She commented it was always important to take food temperatures right before the trayline started to make sure cold foods were below 40 degrees Fahrenheit and hot foods were above 140 degrees Fahrenheit. She explained this gave the staff a chance to bring the food to acceptable temperatures before serving them if they were out of range. The cook stated food temperatures were recorded on trayline temperature sheets which could be reviewed by the DM.	F 371		
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	F 520		1/7/16

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F 520	Continued From page 17 compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility's Quality Assurance (QA) committee failed to identify missing weekly Prothrombin time (PT) and international normalized ratio (INR) labs as a problem to be incorporated into the QA process. This failure to obtain physician-ordered labs resulted in a deficiency in the area of unnecessary medications at tag F329 which the facility was also cited for during its annual recertification survey in February 2015. The citing of F329 during two federal surveys of record showed a pattern of the facility's inability to sustain an effective QA program. Findings included: This tag is cross-referenced to: F329: Unnecessary Medications: Based on record review and staff interview, the facility failed to obtain PT and INR labs for 1 of 5 residents (Resident #5) reviewed for unnecessary medications. During an interview at 4:10 PM on 12/10/15 the assistant director of nursing (ADON) stated the process for tracking labs, including the timely collection of samples to be analyzed by the lab and the communication of those results to the primary physician, had not changed since the	F 520	The QAPI committee met on 12/11/15 to review survey results to include discussion of repeat citation related to F329. The committee also discussed the plan of correction for annual survey 12/7/15-12/10/15. The Division Director of Clinical Service provided re-education to facility department managers and medical director regarding the Quality Improvement Performance Process on 1/7/16. The Divisional Director of Clinical Service and/or the Divisional Director of Operations will attend QAPI meetings weekly times four and monthly times two to ensure that plan of correction has been implemented and maintained. The facility QAPI committee will meet weekly times four and monthly times two to discuss results of audits related to plan of correction for annual survey 12/7/15-12/10/15. The committee will analyze and trend the data to determine if revision to plan of correction is needed.	

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F 520	Continued From page 18	F 520		

failure to draw PT/INR labs for Resident #5 was identified and documented in a variance report. She reported unit managers were responsible for making sure lab collection and result communication was completed without problems, but during the time Resident #5 experienced missing lab draws the facility was without two of its three unit managers.

During an interview at 4:42 PM on 12/10/15 the administrator stated the sources the facility used for identifying issues to incorporate into its QA process included satisfaction surveys, grievance logs, infection control logs, accident reports, and variance reports. He reported variance reports were not part of the medical records, but were kept in the QA binder and submitted to corporate offices. The administrator stated he had not been made aware that Resident #5 went without PT/INR lab collection multiple times. He commented even though this problem appeared to be isolated to Resident #5, and the QA system usually addressed trends, the severity of the problem warranted an ad-hoc session (a session arranged for a very specific purpose) of the QA committee. During this session he explained the facility could determine if other residents were missing labs, changes could be made to the current lab process or a new lab process could be formulated, all staff could be in-serviced about the changes, audits could be completed to evaluate the success of the changes, and the QA committee could make decisions about permanent changes in the lab policy or the need to make further revisions based on audit results. The administrator confirmed that no changes had been made in the lab process since the failure to draw PT/INRs for Resident #5 during July and August 2015. According to the Administrator, the

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F 520	Continued From page 19 facility kept the plan of correction for unnecessary medications in place for an extra two months after its 2014 recertification survey. However, he reported this plan concerned failure of the facility to complete gradual dose reductions of psychotropic medications. The administrator commented the facility's lab process had not been incorporated into the facility's QA process during 2014 and 2015.	F 520		