STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345049	A. BUILDING ______ B. WING ______	03/10/2016

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F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES	F 166		4/7/16

F 166 SS=D — 483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES

A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

This REQUIREMENT is not met as evidenced by:
Based on record review, staff, resident and family interviews, the facility failed to follow their policy in handling grievances and resolving grievances promptly on 2 (Residents #63 & # 72) of 3 sampled residents triggered fro grievances.

1. Resident #63 was admitted to the facility on 5/2/12 with multiple diagnoses including Parkinson's Disease. The quarterly Minimum Data Set (MDS) assessment dated 1/22/16 indicated that Resident #63's cognition was intact.

The facility's policy on " grievances and complaints " dated 5/19/15 was reviewed. The policy read in part " to support each resident's right to voice grievances and to ensure that after a grievance has been received, the facility will actively resolve the issue and communicate the resolution's progress to the resident and/or resident's family in a timely manner. " Under the procedure, the policy indicated that if a grievance was submitted orally, the facility's employee taking the grievance must write it up on the report form. The written grievance was to be forwarded to the administrator within 24 hours of receipt. The administrator will then refer it to the appropriate department head for investigation. The department head will submit a written report of such findings to the administrator within 3

F166 Right to prompt effort to resolve grievances
-
The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.

1. Interventions for affected resident:
Resident #63's missing pants dated 12/30/2015 (3 pairs) were replaced with new pants by the facility on 01/05/2016. The resident and family member were contacted by the Administrator and given $25.49 for the replacement pants purchased by the family member on 01/05/2016.
Resident #72 was reimbursed $15 by the Administrator on 3/18/16.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed   TITLE   (X6) DATE: 03/24/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 166	Continued From page 1 working days of receiving the grievance/complaint. On 3/9/16 at 1:20 PM, Resident #63 and a family member were interviewed. Resident #63 and a family member indicated that 5 new pair of pants were missing since December, 2015. The 5 new pair of pants were labeled with resident's name. A staff member in the laundry and in housekeeping were informed about the missing items last month. The resident and the family member had not heard from the staff any resolution for the missing items. On 3/9/16 at 2:24 PM, the laundry staff member was interviewed. She indicated that a grievance form was given to her for the missing items including the 5 new pair of pants for Resident #63 last week. She added that she had been looking for them in the laundry but could not find them. The grievance form was dated 2/21/16. On 3/9/16 at 2:30 PM, the housekeeping supervisor was interviewed. He stated that the grievance form was given to him by the administrator during the standup meeting in February. The grievance form was dated 2/21/16 and listed the missing items including the 5 new pair of pants. He further added that the staff had been looking for the missing items but were unable to find them. He stated that he didn't know as to when he had to report back to the administrator or the social worker that he was unable to find the missing items. On 3/10/16 at 11:45 AM, the Director of Nursing (DON) was interviewed. The DON agreed that the grievance was not handled timely if it was brought to the attention of the staff on 2/21/16.	F 166	2. Interventions for residents identified as having the potential to be affected: The Administrator audited current grievances for timely follow up and resolution on 3/21/16. No other grievances were left unresolved within the allotted time frame. Housekeeping employees and the Housekeeping Manager were re-educated by the Director of Nursing on the policy for reporting grievances and missing items, follow up of grievances, and timely resolution of grievances on 3/31. Licensed Nurses were re-educated by the Director of Nursing on the policy for reporting grievances and missing items, follow up of grievances, and timely resolution of grievances on 3/31. All remaining staff to include PRN and weekends were re-educated on 3/31. 3. Systematic Change: The Social Worker will perform a weekly audit of grievance logs for 12 weeks to ensure timely follow up and resolution of each reported grievance. Newly hired facility staff will be educated during their orientation period on the policy for reporting grievances and missing items, follow up of grievances, and timely resolution of grievances. 4. Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three (3) months, the Social Worker will report audit findings from the weekly audits of	

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F 166	Continued From page 2	F 166	the grievance logs to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three (3) months.	

2. Resident #72 was admitted to the facility on 2/12/16. The admission MDS assessment dated 2/19/16 indicated that Resident #72's cognition was intact.

On 3/7/16 at 1:51 PM, Resident #72 was interviewed. Resident #72 indicated that she had lost $15 last week. Her family member had given her the money and she put it on the pocket of her pants. The next day the $15 was missing. Resident #72 stated that she reported the missing money to Nurse # 3 last week.

The grievance forms were reviewed. There was a grievance form written for Resident #72 dated 3/7/16.

On 3/7/16 at 4:50 PM, Nurse #5 was interviewed. Nurse #5 was not aware of the missing money for Resident #72. She indicated that she would talk to Resident #72 and would get back with me. At 5:05 PM, Nurse #5 stated that she had talked with Resident #72 who indicated that she lost $15 and she had reported it to Nurse #3 last week. Nurse #5 also stated that she would inform the social worker about the missing money.

On 3/8/16 at 10:15 AM, Social Worker (SW) #2 was interviewed. SW #2 stated that she was informed on 3/7/16 that Resident #72 had money missing. She went to talk to the resident who confirmed that she had lost $15 last week. She filled out the grievance form and the resident was reimbursed with $15.

On 3/9/16 at 8:35 AM, Nurse #3 was interviewed.

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F 166	Continued From page 3 Nurse #3 indicated that he heard about the missing money last week. He went to talk to Resident #72 who stated that she lost $15 but not sure if it was lost or misplaced so he did not report it to anybody.	F 166		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff and resident interviews, the facility failed to respond to a resident's request for assistance in a timely manner for 1 (Resident # 72) of 4 sampled residents reviewed for dignity and failed to knock on door and requesting permission to enter for 1 (Resident #5) of 5 sampled residents reviewed for dignity. Findings included: 1. Resident #72 was admitted to the facility on 2/12/16 with multiple diagnoses including end stage renal disease on dialysis. The admission Minimum Data Set (MDS) assessment dated 2/19/16 indicated that Resident #72 ' s cognition was intact and she needed extensive assistance with bed mobility. The assessment also indicated that Resident #72 had no behavior. Resident #72 was interviewed on 3/7/15 at 1:51 PM. She indicated that she had concerns with	F 241	F241 Dignity and respect of individuality The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1. Interventions for affected resident: Resident #72 received assist with repositioning on 3/9/16 by LN 2, 3. The resident also received their requested soup and sandwich on 3/9/16. NA#1 and	4/7/16

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F 241	Continued From page 4 the staff not answering the call lights for more than 30 minutes. On 3/9/16 at 2:45 PM, Resident #72 was observed in bed. She indicated that she was very uncomfortable on her position, weak and tired from dialysis. She also stated that she was hurting and hungry. Her call light was activated and a nursing aide (NA#1) was observed to enter the room, turned off the call light and left the room without asking the resident what she needed. NA#1 was saying that she would tell the resident ' s nurse aide as she was leaving the room. Resident #72 continued to express the need to be repositioned in bed as she was uncomfortable and hurting. After 15 minutes of waiting, a family member who was visiting, went to get a staff member. Two nurses (Nurse #2 & Nurse #3) were observed to enter the room to assist the resident in repositioning in bed. After being repositioned in bed, Resident #72 stated to Nurse #2 that she had requested soup and a sandwich but it had not come yet. On 3/9/16 at 3:05 PM, Resident #72 was interviewed. She stated that she arrived from dialysis around 1 PM and her lunch tray had been sitting at the bedside table. She didn't want to eat it because the food was cold, so she asked for soup and a sandwich. She added that she had been waiting for it since then. She stated that she rang the call bell at 1:45 PM and nobody answered it. She added that this was a problem at this facility, nobody would answer the call light or staff would come in the room, turn it off without asking what you need. She indicated that she felt helpless and she was hungry because she had not yet had lunch.	F 241	NA#2 were re-educated by the Director of Nursing on how to answer call lights timely and to ask the resident how they can assist them before leaving the room on 03/09/16. NA#1 and was re-educated by the Director of Nursing of the procedure for knocking on doors before entering the patients□ rooms on 03/09/16 2. Interventions for residents identified as having the potential to be affected: The DON immediately, on 3/9, discussed this situation with Department staff to remind them to answer call lights immediately and to knock or say, "knock, knock" if their hands are full to avoid further incidents with other residents in the facility. The DON informed 2nd shift UM to pass this information to night shift. To ensure that residents are not waiting on call lights,facility staff to include weekends and PRN were re-educated on 3/31 by the DON on the procedures for answering call lights timely. They were also re-educated to ask the resident what he/she needs before leaving the room and to knock on doors before entering patient rooms to allow for privacy. They were re-educated to stop documentation and provide care promptly. 3. Systematic Change: Newly hired Licensed Nurses and CNAs and all other facility staff to include admin, sw, dietary, etc. will be educated on the procedures for answering call lights timely during their orientation period. They will also educated to ask the resident what	

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F 241	Continued From page 5 On 3/9/16 at 3:25 PM, NA #1 was interviewed. NA #1 stated that she was not assigned to Resident #72 but she had informed Nurse #3 after she left the room that Resident #72 needed help. On 3/9/16 at 3:30 PM, Nurse #3 was interviewed. Nurse #3 stated that he was informed that Resident #72 needed help and he then informed NA#2 who was assigned to the resident. NA #2 was at the nurse's station at that time doing her documentation on the computer. On 3/9/16 at 3:35 PM, NA #2 was interviewed. She stated that she was assigned to Resident #72. She acknowledged that she was informed that Resident #72 needed help. She was finishing her documentation on the computer and was planning to see the resident when she finished. On 3/10/16 at 11:45 AM, the Director of Nursing was interviewed. He indicated that he expected the staff to ask the resident what he/she needs before leaving the room. 2. According to a significant change Minimum Data Set dated 2/6/16, Resident #5 had no problems with long or short term memory. She was interviewed on 3/8/16 at 8:02 AM, the door of the room was closed. Nurse Aide #1 entered the room with the resident's breakfast tray without knocking. The resident said this aide was the only one who does not knock. Upon conclusion of the interview at 8:34, Nurse Aide #1 was asked why she did not knock. She said she knocked on the door with the breakfast tray before entering the room. The Director of Nurses and Administrator were notified of the occurrence on	F 241	he/she needs before leaving the room and to knock on doors before entering patient rooms to allow for privacy by SDC. The Director of Nursing or Assistant Director of Nursing will audit call light wait times and communication regarding patient needs before leaving the room for 5 random call lights weekly for 12 weeks. The Director of Nursing or Assistant Director of Nursing will also audit for knocking on patient room doors on one resident per week per floor weekly for 12 weeks. 4. Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three (3) months, the Director of Nursing or Assistant Director of Nursing will report audit findings from the weekly audits of call light wait times, communication regarding patient needs before leaving the room, and knocking on doors before entering residents□ rooms to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three (3) months.	

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F 241	Continued From page 6 3/10/16.	F 241		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, family interview and record review, the facility failed to maintain clean edges and corner of floors in resident rooms, walls and baseboards that were free from marring and scuffs in 28 of 91 resident rooms (202, 203, 209, 210, 212, 220, 227, 301, 307, 314, 317, 318, 320, 324, 326, 328, 332, 336,403,407, 409, 410, 411, 414, 420, 424, 427, 430); replace three cracked wheel chair arms (Resident #s 5, 33 and 111); repair a faucet that could not be turned off (411) and replace a missing threshold (424). Findings included. 1) The following observations were about cracked arm rests on residents ' wheel chairs. a) Observation on 3/07/2016 at 1:42 PM revealed the right arm rest of Resident #5 ' s wheel chair was taped. b) Observation on 3/07/2016 02:56 PM revealed a cracked arm rest on the wheelchair for Resident #33. On 3/09/2016 at 10:24 AM to 10:39 AM, the wheel chair ' s left arm rest remained cracked. c) Observation on 3/07/2016 at 02:11 PM revealed Resident #111 ' s wheelchair arm rest was cracked and the front rim the seat was crack, too.	F 253	F253 Housekeeping and Maintenance Services The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1. Interventions for affected resident: Rooms 202, 203, 209, 210, 212, 220, 227, 301, 307, 314, 317, 318, 320, 324, 326, 328, 332, 336, 403, 407, 409, 410, 411, 414, 420, 424, 427, and 430 were deep cleaned by housekeeping staff from 3/11/16 to 4/7/2016 to ensure edges, corners, walls, and baseboards were free of dirt, debris, and scuffs.	4/7/16

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F 253	Continued From page 7 2) Observations revealed the following concerns with residents ' rooms. a) Observation on 3/07/2016 at 10:17 AM revealed paint was chipped, walls were scuffed behind the bed and there was a stain on the ceiling in room 314. b) Observation on 3/07/2016 at 1:41 PM revealed walls in the entry way of room 403 were scuffed. The edges of the floor were dirty. This was observed again on 3/09/2016 from 9:57 AM to 10:20 AM. c) Observation on 3/07/2016 at 3:14 PM revealed the walls in room 317 were scarred. d) Observation on 3/07/2016 at 1:46 PM revealed the wall behind bed B was scarred in room 409. On 3/09/2016 from 9:57 AM to 10:20 AM there was built up dirt behind the door, the wall behind Bed B, the dresser and baseboards were scarred. e) Observation on 3/07/2016 at 1:54 PM revealed the wall behind bed B was marked. The baseboards were soiled and the faucet in the bathroom could not be turned off in room 411. On 3/09/2016 from 9:57 AM to 10:20 AM, the wall next to the bed contained on old spill and the wall was scarred behind the bed. f) Observation on 3/07/2016 at 2:55 PM revealed the walls in room 332 were scarred behind the bed and the baseboards were dirty. On 3/09/2016 at 10:24 AM to 10:39 AM, the wallpaper in room 332 behind Bed A had a long, narrow white strip on it and holes in the wall. g) Observation on 3/07/2016 at 1:01 PM revealed the threshold was missing leading to the bathroom in room 424. h) Observation on 3/07/2016 at 2:18 PM revealed two holes in the wall next to the clock and a scarred wall in room 407. On 03/09/2016	F 253	The cracked wheelchair arms and cracked seats for resident #5, #33, and #111□s wheelchairs were ordered on 03/24/2016 by Central Supply can and will be placed on each by Maintenance by 4/7/16. NOTE: All repairs will be completed between 3/11- 4/7. Room 314: The walls were repaired and painted. The stain was removed and painted. A bumper guard is being added to the bed to protect further damage behind the bed. Room 403: Walls were repaired and painted. The cove base was changed and the floors were cleaned. Room 317: The walls were repaired and painted. A bumper guard was placed on the bed. Room 409: The wall was repaired and wall guards were ordered to be placed behind the bed. The baseboards were replaced. Room 411: The faucet was replaced on 3/17 and the walls were repaired and wall guards were placed behind the the bed. The bumper guards were added to the bed. Room 332: The walls were repaired and wall guards were added along with bed bumpers. Room 424: The threshold was replaced. Room 407. The holes were repaired. The walls were repaired and the baseboard was replaced. The room was deep cleaned. Room 307: The walls were repaired and bumpers were added to avoid further damage. The baseboards were changed. Rooms 202, 203, 209, 210, 212, 220, 227:	

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from 9:57 AM to 10:20 AM 407, torn wallpaper was noted by Bed B, the baseboard was separating from the wall under the window, a soiled wall and built up dirt behind the door.

i) Observation on 3/07/2016 at 11:01 AM revealed scuff marks behind the bed, a stain on the corner of the ceiling and wall in room 307.

The following rooms were observed on 3/09/2016 from 9:48 AM to 9:53 AM to have walls with scuffs, mars or peeling wallpaper.

j) 202 scuffed wall at entrance.
k) 203 scuffed wall at entrance on both sides.
l) 209 scuffed walls.
m) 210 scuffed walls.
n) 212 scuffed walls.
o) 220 scuffed walls.
p) 227 hallway wallpaper was separated from the wall.

Observations on 03/09/2016 from 9:57 AM to 10:20 AM revealed:

q) the left lower corner of the closet was chipped in room420.
r) the baseboards were dirty and walls scuffed in room 427.
s) the baseboards and edges behind door were dirty in room 430.
t) the baseboards in room 414 were dirty.

During this observation Resident #4 said, " When they mop, they just go down center. They spend tremendous time polishing floors. They do not get edges. " This resident ' s most recent assessment dated 2/25/16 indicated she had no cognitive problems.

u) the wall next to the bed had an old spill and the wall was scarred behind the bed in room 411.

F 253

All walls were repaired as noted.
Baseboards were changed and bumpers and wall boards added as necessary to avoid further damage.
Rooms 420, 427, 430, 414: All baseboards were changed and rooms were cleaned and walls were repaired as painted.
Room 411: Wall protection board was added to avoid further damage and bumper guards were added to the bed. The walls were painted and bumpers were added.
Room 410: The wall was repaired, painted and bumpers were added.
Room 318: The baseboards were replaced.
Room 320: The baseboards were replaced. The door was repaired and the paint was changed.
Rooms 326, 328, 336, 301: The baseboards were replaced.

2. Interventions for residents identified as having the potential to be affected:
The Housekeeping Manager and Maintenance Supervisor audited resident rooms for the need for deep cleaning and repairs on 03/25/16. Additionally, the Administrator, HK Supervisor and Maintenance Supervisor audited remaining resident rooms to document improvements on 3/25. Rooms in need of deep cleaning or repairs were added to the schedule for deep cleaning and work orders for created for Maintenance repairs.
3. Systematic Change:
Housekeeping employees were

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v). the wallpaper was torn and separated at seams near Bed A in room 410.

Observations on 3/09/2016 at 10:24 AM to 10:39 AM on 3rd floor revealed:
w) the baseboard near Bed A and the wall behind Bed B was scarred in room 318.
x) the paint was faded, the baseboards were scarred and the bathroom door contained a hole in room 320.
y) the wall board was torn near Bed A in room 324.
z) the baseboard was separated from the wall in room 326.
aa) the baseboard behind Bed B had torn wallpaper near the bathroom door. The bathroom door was dirty in room 328.
bb) the baseboard was cracked at the bathroom in room 336.
cc) the baseboard was scarred in room 301.

3) During a family interview on 3/07/2016 at 3:36 PM, the family was asked, " Is the building clean? " and the response was the walls needed painting.

Housekeeper #2 was observed cleaning the edges of the floor on 3/09/2016 10:39 AM. Observation on 3/09/2016 at 10:20 AM revealed Housekeeper #1 making his way down to the lower end of hall. He was observed mopping the surface of floor in Room 412.

On 3/09/2016 at 10:41 AM Housekeeper #3 described routine cleaning. We wipe doors, light switches, dust air conditioner, TV, and clean beds, sink and toilet. On 3/09/2016 10:26 AM routine cleaning includes beds & bathrooms per Housekeeper #4. They mop, dust and wipe

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re-educated by the Housekeeping Manager on cleaning procedures and the schedule for deep cleaning of rooms on 3/14. Maintenance staff will be re-educated by the Administrator on preventive maintenance for resident rooms on 3/31.

Newly hired Housekeeping employees will be educated by the Housekeeping Manager on cleaning procedures and the schedule for deep cleaning of rooms. Newly hired Maintenance staff will be educated by the SDC on preventive maintenance for resident rooms.
The Administrator along with the Housekeeping Manager and the Maintenance Supervisor will audit one Housekeeping assignment of each floor weekly for 12 weeks to ensure cleanliness and that rooms are in good repair. The Area Manager and Administrator will conduct a monthly audit and provide results to HK Manager and Maintenance Supervisor.

4. Monitoring of the change to sustain system compliance ongoing:
Monthly for a minimum of three (3) months, the Administrator will report audit findings from the weekly audits of cleanliness and repairs of resident rooms to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further

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F 253	Continued From page 10 down. They strip floors as needed. The Maintenance Director was interviewed on 3/09/2016 10:56 AM. The maintenance concerns were reviewed with him. He said weekly, monthly and quarterly checks were conducted on a variety of items. He said, " We paint every day. We are in the process of changing out sheet vinyl in every bathroom and have been replacing bathroom floors. " He stated the walls behind the bed get scarred often and some bumpers had been purchased in the past. He said the maintenance department consisted of him and his assistant. He said there were no plans for full renovation. He said he was aware of the problems they chisel away at it. On 3/09/2016 at 11:09 AM the Housekeeping Supervisor said they do deep cleaning based on a planned schedule. On 03/09/2016 at 11:15 AM the elevator was observed in the presence of the Housekeeping Supervisor to have lots of dirt in the tracks. He said that happened when the floor was buffed. On 03/09/2016 at 11:28 AM the findings were shared with the Administrator. He stated a resident would have to be out of a room for three days if they replaced wallpaper. He said resources are put into maintenance and housekeeping. He said rounds are done weekly with the Maintenance Director and the Housekeeping Supervisor ' s Manager. He said the edges of floors should be cleaned. Painting was done all of the time. Monthly Unit Inspection reports were reviewed for December 2015 and February 2016. The	F 253	auditing beyond the three (3) months.	

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F 253	Continued From page 11 inspection is a comprehensive reviews of the entire building and grounds and it includes an audit of six resident rooms on each report. The December report identified unsatisfactory conditions with floors, baseboards and corners and edges in resident rooms. The February report identified unsatisfactory conditions with walls, floors, corners and edges in resident rooms. Deep cleaning schedules revealed six rooms were planned for deep cleaning every day from Monday - Friday. Monthly Floor Tech and Housekeeping Project Schedules were provided.	F 253		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each	F 278		4/7/16

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F 278	Continued From page 12 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 facility failed to accurately code the Preadmission Screening and Resident Review (PASRR) on the annual Minimum Data Set (MDS) for one of one residents (Resident #17) reviewed for PASRR. The findings included: Resident #17 was admitted to the facility on 5/22/14 and readmitted on 2/11/16 with multiple diagnoses including a history of a cerebral vascular accident, vascular dementia, and major depressive disorder. A review of the PASRR Level Determination Notification dated 10/13/14 revealed Resident #17 was coded as a level II PASRR. A review of the annual MDS dated 4/28/15 revealed Resident #17 was not coded as a level II PASRR. An interview was conducted with the Social Services Manager on 3/9/16 at 8:45 AM. She stated she was responsible for completing the PASRR section of the MDS. She stated that Resident #17 was a level II PASRR due to intellectual disability. She stated she incorrectly coded the PASRR level on the annual MDS dated 4/28/15.	F 278	F278 Assessment Accuracy/Coordination/Certified The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1. Interventions for affected resident: The Annual MDS dated on 4/28/15 for resident #17 was corrected on 03/10/16 to include the correct coding as a level II PASSR by the MDS Nursing Manager. 2. Interventions for residents identified as having the potential to be affected: The MDS Nurse completed a 100% audit of remaining MDSs for current residents with a Level II PASSR on 3/10/2016 to ensure correct coding of the Level II PASSR on the MDS. There were other findings and they were corrected on 3/10	

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F 278	Continued From page 13	F 278	with a modified MDS by the MDS Supervisor. 3. Systematic Change: The Social Workers were re-educated by the MDS Nurse on 3/11 on correct coding of PASSRs on the MDS (Minimum Data Sets). Newly hired Social Workers will be educated by the MDS Nurse or Director of Nursing on correct coding of PASSRs on the MDS (Minimum Data Sets). 4. The MDS Nurse will audit 3 MDS Assessments weekly for 12 weeks for monitoring correct coding of the PASSR on the MDS. Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three (3) months, the MDS Nurse will report audit findings from the weekly audits of PASSR coding on the MDS□s to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three (3) months.	
F 333 SS=E	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors.	F 333		4/7/16

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F 333	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to administer a medication as ordered by the physician for 1 (Resident #33) of 5 sampled residents reviewed for unnecessary drugs. Findings included: Resident #33 was admitted to the facility on 4/29/11 with multiple diagnoses including Diabetes Mellitus. The quarterly Minimum Data Set (MDS) assessment dated 12/21/15 indicated that Resident # 33's cognition was intact. The medical records for Resident #33 were reviewed. The March, 2016 physician's orders included Vitamin D 3 50,000 units, take one capsule by mouth twice a month on the 1st and 15th of the month for Vitamin D deficiency. Vitamin D 3 was ordered on 9/11/14. On 12/14/15, there was a doctor order to check Vitamin D level for Resident #33. The result was 24. The normal range for Vitamin D was 30-100. The 12/14/15 laboratory report for the Vitamin D level was seen by the doctor on 12/15/15. The doctor ordered to change Vitamin D 3 50,000 units from twice a month to weekly and to check the level in 4 months. Resident #33's Medication Administration Records (MARs) for January and February 2016 were reviewed. Vitamin D 3 was administered to Resident #33 twice a month instead of weekly as ordered.	F 333	F333 Free of Significant Med Errors The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1. Interventions for affected resident: Physician for resident #33 was notified by UM on 3/10/16 that the Vitamin D 3 order from 12/15/15 was not carried out. An order to check Vitamin D level was received. On 3/10/2016, new orders were received by UM from MD. 2. Interventions for residents identified as having the potential to be affected: On 3/11/16, the Director of Nursing, Assistant Director of Nursing, and Nursing Supervisors audited medication orders received over the past 30 days to ensure orders were added or updated on the Medication Administration Records to ensure other residents were not affected. There were no additional findings resulting from this review.	

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F 333	Continued From page 15 On 3/10/16 at 9:40 AM, Nurse #1 was interviewed. Nurse #1 stated that the laboratory report was faxed to the doctor's office and the doctor writes his order on the report. The order written on the laboratory report was considered a doctor's order. Nurse #1 confirmed that the doctor's order to change the Vitamin D 3 to weekly on 12/15/15 was not transcribed to the MARs and therefore Vitamin D 3 was not administered weekly as ordered. On 3/10/16 at 9:50 AM, the Assistant Director of Nursing was interviewed. She stated that she would inform the doctor for Resident #33 that the Vitamin D 3 ordered to be given weekly on 12/15/15 was not carried out and will get an order to recheck the Vitamin D level.	F 333	3. Systematic Change: Licensed Nurses to include weekends, nights and PRN will be re-educated on 4/5 by Director of Nursing or Assistant Director of Nursing on the proper procedure for transcribing new orders to the Medication Administration Record (MAR) and Treatment Administration Record (TAR). The Director of Nursing or Assistant Director of Nursing re-educated Licensed Nurses on the twenty-four (24) hour chart check process which will include checking physician orders from the previous day to verify transcription of new orders to the Medication Administration Record (MAR) and/or Treatment Administration Record (TAR). Newly hired Licensed Nurses to include weekends, nights and PRN will be educated during their orientation period by the facility Director of Nursing, Staff Development Coordinator or Unit Manager on the process of transcribing new orders to the Medication Administration Record (MAR), Treatment Administration Record (TAR) and the twenty-four (24) hour chart check process. 4. Monitoring of the change to sustain system compliance ongoing: Night shift Licensed Nurses will perform a twenty-four (24) hour chart check process which will include checking each resident medical record for new physician orders from the previous day to verify transcription of new orders to the Medication Administration Record (MAR) and Treatment Administration Record (TAR). Director of Nursing, Staff Development	

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F 333	Continued From page 16	F 333	Coordinator and/or Unit Manager will audit twelve (12) chart checks weekly to ensure twenty-four (24) hour chart check process is completed and any new physician orders from the previous day are transcribed to the resident Medication Administration Record (MAR) and/or Treatment Administration Record as applicable. Audit will be performed weekly for twelve (12) weeks Monthly for a minimum of three (3) months, the Director of Nursing will report audit findings from the twenty-four (24) hour chart check process to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three (3) months.	
F 372 SS=D	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to contain liquid waste in one of two dumpsters. Findings included: Observation of two dumpsters on 3/6/2016 at 3:30 PM with the Dietary Manager revealed some leakage from the dumpster nearest the building	F 372	F372 Dispose garbage and refuse properly The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is	4/7/16

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on the side near the plug. The Dietary Manager said he would report the problem.

Observation of the dumpster on 3/08/2016 at 3:13 PM revealed a whitish substance leaking from the corner of the dumpster and streaming approximately 12 yards toward the parking area on the pavement. Interview with the Maintenance Director revealed he identified the leak on Sunday and left a message with the waste company to replace the dumpster. Further interview on 3/08/2016 at 3:52 PM revealed the waste company was contacted again and they said they replaced the plug on the dumpster. The Maintenance Director explained the leak was not from the plug, it was leaking from bottom. He was told it would be replaced on 3/9/16.

Observation of the dumpster on 3/09/2016 at 7:00 AM revealed the same dumpster. The pavement looked like it had been hosed down. Some whitish residue was observed from the leaking corner of dumpster.

Interview with the Maintenance Director on 3/09/2016 at 8:03 AM revealed the dumpster was replaced.

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completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.

1. Interventions for affected resident:
No residents were affected by the finding.
Both dumpsters were replaced on 3/9/16 by Waste Management.
2. Interventions for residents identified as having the potential to be affected: No residents were affected by this finding.
The Maintenance Supervisor observed on 3/5- 3/9 dumpsters for any further leakage. On 3/5, MS notified waste management of the leakage. On 3/6, Waste Management changed the plug and it continued to leak through the seam. On 3/9, both dumpsters were replaced by new ones.
3. Systematic Change:
The Administrator re-educated the Maintenance Supervisor and Dietary Manager on the procedure for disposing of garbage and refuse properly on 3/11.

4. Monitoring of the change to sustain system compliance ongoing:
The Maintenance Supervisor, Administrator and HK Supervisor began on 3/11 observing dumpsters weekly for 12 weeks to ensure that garbage and refuse are disposed of properly and that

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F 372	Continued From page 18	F 372	there are no leaks in the dumpsters. Monthly for a minimum of three (3) months, the Maintenance Supervisor or Administrator will report audit findings from the weekly dumpster audits to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three (3) months.	
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and interview with the pharmacist, the facility failed to report drug irregularity to the Director of Nursing (DON) for 1 (Resident #33) of 5 sampled residents reviewed for unnecessary drugs. Findings included: Resident #33 was admitted to the facility on	F 428	F428 Drug regimen review, report irregular, act on The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is	4/7/16

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4/29/11 with multiple diagnoses including Diabetes Mellitus. The quarterly Minimum Data Set (MDS) assessment dated 12/21/15 indicated that Resident # 33's cognition was intact.

The medical records for Resident #33 were reviewed. The March, 2016 physician's orders included Vitamin D 3 50,000 units, take one capsule by mouth twice a month on the 1st and 15th of the month for Vitamin D deficiency. Vitamin D 3 was ordered on 9/11/14.

On 12/14/15, there was a doctor's order to check Vitamin D level for Resident #33. The result was 24. The normal range for Vitamin D was 30-100.

The laboratory report for the Vitamin D level was seen by the doctor on 12/15/15. The doctor ordered to change Vitamin D 3 from twice a month to weekly and to check the level in 4 months.

Resident #33's Medication Administration Records (MARs) for January, February and March, 2016 were reviewed. Vitamin D 3 was transcribed and administered to Resident #33 twice a month instead of weekly as ordered.

On 3/10/16 at 9:40 AM, Nurse #1 was interviewed. Nurse #1 stated that the laboratory report was faxed to the doctor's office and the doctor writes his order on the report. The order written on the laboratory report was considered a doctor's order. Nurse #1 confirmed that the doctor's order to change the Vitamin D 3 to weekly was not transcribed to the MARs and therefore Vitamin D 3 was not administered weekly as ordered.

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completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.

1. Interventions for affected resident:
Physician for resident #33 was notified by UM on 3/10/16 that the Vitamin D 3 order from MD on 12/15/15 was not carried out. An order to check Vitamin D level was received. New orders were received from MD by UM on 3/10/16.
2. Interventions for residents identified as having the potential to be affected:
On 3/12, The Director of Nursing, Assistant Director of Nursing, and Nursing Supervisors audited facilty medication orders for all residents received over the past 30 days to ensure orders were added or updated on the Medication Administration Record. There no further errors noted during this review.
3. Systematic Change:
The Director of Nursing met with Pharmacist Consultant on 3/31 to review the procedure for documentation of Physician Orders and the process for transcribing Physician Orders to the Medication Administration Record. The Director of Nursing also reviewed the expectation for the Pharmacist Consultant to review resident medications regimens monthly and to report any discrepancies.

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F 428	Continued From page 20 The pharmacist's monthly drug regimen reviews (DRR) were reviewed. The drug regimen reviews dated 1/27/16 and 2/26/16 did not address the irregularity for the Vitamin D 3. On 3/10/16 at 11:21 AM, the pharmacist was interviewed. She indicated that she had reviewed the records for Resident #72 and she might have missed to report to the DON the new order for Vitamin D 3 not being followed or was not able to review the Medication Administration Records (MARs) because they were not available in the chart at the time of the review.	F 428	4. Monitoring of the change to sustain system compliance ongoing: The Director of Nursing will audit 10 Pharmacist Monthly Reviews monthly for 3 months to ensure there were no missed orders. Monthly for a minimum of three (3) months, the Director of Nursing will report audit findings from Monthly Pharmacist Review to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three (3) months.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in	F 431		4/7/16

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F 431	Continued From page 21 locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to discard an expired Novolog insulin vial and failed to store an opened bottle of Lantus with federally mandated labeling in 1 of 7 medication carts (Medication Cart # 1). Findings included: Medication storage inspection was conducted on 3/6/16 at 4:00 PM. 1. An opened bottle of Novolog was dated as opened on 2/6/16. Manufacturer recommendations show that an open bottle of Novolog expires in 28 days. Nurse #4 was interviewed on 3/6/16 at 6:15 PM. She stated "I believe insulin has an expiration date of 30 days." She later confirmed that the expiration of Novolog vials is 28 days and stated "It should have been thrown away yesterday."	F 431	F431 Drug records, label/store drugs and biologicals The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1. Interventions for affected resident: No residents were affected by this finding. The opened bottle of Novolog dated	

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	345049	A. BUILDING ______ B. WING ______	03/10/2016

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F 431	Continued From page 22 The Director of Nursing was interviewed on 3/10/16 at 9:00 AM. He stated "Staff checks the medication carts weekly for expired or unlabeled medications. My expectation is that it should have been found and disposed of." 2. An opened unlabeled bottle of Lantus insulin was found in the medication cart insulin drawer. Nurse #4 was interviewed on 3/6/16 at 6:15 PM. She stated "I don ' t know why this is here; I have not used insulin from this bottle today. I am going to chuck it (dispose) right now." The Director of Nursing was interviewed on 3/10/16 at 9:00 AM. He stated "Staff checks the medication carts weekly for expired or unlabeled medications. My expectation is that it should have been found and disposed of."	F 431	2/6/16 was disposed of on 3/6/16 by Nurse #4.. 2. Interventions for residents identified as having the potential to be affected: Facility medication carts on 3/8 were audited and all remaining residents with opened insulin bottles were checked for dates by Unit Managers and to ensure they had not expired to ensure that no other residents were affected. There were no further expired meds or meds unlabeled from this observation on 3/9. 3. Systematic Change: Licensed Nurses were re-educated by the Director of Nursing or Assistant Director of Nursing on 3/12 that Novolog expires in 28 days from the date the bottle was opened. Novolog bottles to be labeled and date upon opening are to be discarded upon expiration date. All nurses to include weekends and PRN will be re-educated on labeling and expiration of medications on 4/5. During orientation, the SDC will educate newly hired Licensed Nurses to include PRN and weekend staff will be educated regarding both unlabeled and Novolog expiring in 28 days from the date the bottle was opened. Novolog bottles are to be discarded upon expiration date. 4. Monitoring of the change to sustain system compliance ongoing: The Director of Nursing, Assistant Director of Nursing or Nurse Supervisor will audit 2 facility med carts twice a week for 12 weeks to ensure Insulins are dated and disposed of on their expiration date. Monthly for a minimum of three (3)	

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F 431	Continued From page 23	F 431	months, the Director of Nursing will report audit findings from Medication cart audits to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three (3) months.	
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment 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.	F 520		4/7/16

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F 520	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, family interview and record review, the facility ' s Quality Assessment and Assurance committee failed to implement, monitor and revise as needed the action plan developed for the 5/20/15 recertification survey. The facility had a pattern of repeat deficiencies on accurate coding of the Minimum Data Set (MDS) and for housekeeping and maintenance services on the 5/20/15 recertification survey. The findings included: This tag is cross referenced to: 1 a. F 278. Assessment Accuracy: Based on record review and staff interview, the facility failed to accurately code the Preadmission Screening and Resident Review (PASRR) on the annual Minimum Data Set (MDS) for one of one residents (Resident #17) reviewed for PASRR. On the recertification survey of 05/20/15, the facility failed to accurately code the MDS regarding dialysis for a resident reviewed for dialysis and failed to accurately code level 2 PASRR on the admission and annual MDS for a resident. On the current recertification survey, the facility again failed to accurately code a resident assessed with a level 2 PASRR. b. F 253. Housekeeping and Maintenance Services: Based on observation, resident interview, staff interview, family interview and record review, the facility failed to maintain clean edges and corner of floors in resident rooms, walls and baseboards that were free from marring	F 520	F520 QAA Committee/Meet Quarterly/plans The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1. Interventions for affected resident: No residents were named in this citation, however, facility residents have the potential to be affected. 2. Interventions for residents identified as having the potential to be affected: On 3/11, the MDS Nurses and Social Workers were re-educated by the Director of Nursing on correct coding of Section A of the MDS regarding PASRRs and Section O regarding treatments and procedures to include Dialysis when applicable. On 3/14, all housekeeping employees were re-educated by the Housekeeping Manager on cleaning procedures and the schedule for deep cleaning of rooms on. On 3/11, maintenance staff were	

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F 520	Continued From page 25 and scuffs in 28 of 91 resident rooms (202, 203, 209, 210, 212, 220, 227, 301, 307, 314, 317, 318, 320, 324, 326, 328, 332, 336,403,407, 409, 410, 411, 414, 420, 424, 427, 430); replace three cracked wheel chair arms (Resident #s 5, 33 and 111); repair a faucet that could not be turned off (411) and replace a missing threshold (424). On the recertification survey of 05/20/15 the facility failed to provide maintenance and housekeeping services necessary to maintain a safe and clean interior. On the current recertification survey, the facility failed to maintain cleanliness, resident equipment, and resident rooms. An interview was conducted with the Administrator on 3/10/16 at 12:30 PM. The Administrator stated he believed the error in the MDS coding was due to an oversight. The Administrator stated remodeling of the resident rooms has been a lengthy process. He stated that the first floor of the building has been remodeled and plans to remodel the 2nd, 3rd and 4th floors were in process. He stated there was improvement needed in the housekeeping department.	F 520	re-educated by the Administrator on preventive maintenance for resident rooms. 3. Systematic Change: The Director of Nursing or Assistant Director of Nursing will audit 5 MDSs monthly for 6 months for correct coding of section A6 regarding level II PASSRs and section O regarding treatments and procedures. The Administrator or Maintenance Supervisor will audit 2 resident rooms per floor monthly for 6 months for cleanliness, and the need for repairs to the floors, walls, or fixtures. Education of QAPI members on the intent of the citations F253 and F278 monthly x 3 months at the QAPI meeting by the Administrator and/or RCD. 4. Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of six (6) months, the Director of Nursing will report audit findings from MDS coding audits to the Quality Assurance and Performance Improvement Committee. Monthly for a minimum of six (6) months, the Administrator will report audit findings from resident room audits to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the six (6) months.	