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	345128	A. BUILDING _____ B. WING _____	C 04/01/2016

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BRIAN CENTER HEALTH & REHABILITATION/STATESVILLE	520 VALLEY STREET STATESVILLE, NC 28677

(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 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 and staff interviews the facility failed to repair resident doors with broken and splintered laminate and wood on 4 of 5 halls, failed to repair smoke barrier doors with broken and splintered laminate and wood on 1 of 5 halls, and paint the door of a nourishment room. The facility also failed to clean an arm trough on a resident's wheelchair (Resident #1), and failed to cover a plunger in a shared bathroom on 1 of 5 halls. The findings included: 1. a. Observations of Room 224 on 03/29/16 at 1:11 PM revealed the door of the residents' room had a dime-sized area with broken and splintered laminate on the edges of the door just above the bottom door hinge. The bottom edge of the bathroom door had broken and splintered laminate. b. Observations of Room 227 on 03/29/16 at 1:11 PM revealed the door of the residents' room had broken and splintered laminate on the edges of the door above and below the door jam. The bottom edge of the bathroom door had broken and splintered laminate. c. Observations of Room 304 on 03/29/16 at 3:40 PM revealed the door of the residents' room had	F 253	Criteria 1 The Maintenance Director repaired, painted or stained doors for Rooms 224,227,304,307,302, 138, 301, 303, 134, and 403 by 4-25-16. The Maintenance Director removed the toilet plunger from Resident # 1's bathroom by 4-25-16. Resident #1's arm trough was cleaned. Criteria 2 All Resident's with Rooms having damaged door are at risk of being affected by this alleged deficient practice. Criteria 3 Every Resident door and every bathroom door and every smoke containment door was repaired, painted or stained as needed. These repairs, painting and staining were completed by 4-25-16. The Maintenance Director completed an audit of Resident Bathrooms to remove other toilet plungers. This audit and removal was completed by 4-25-16. The administrator will audit the building weekly for dirty equipment and see that it is cleaned x 4 weeks. Nursing Staff and Housekeeping Staff were re-educated by the Administrator regarding the process for completion of maintenance request forms when repair needs are identified and storage of toilet	4/29/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/25/2016

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F 253	Continued From page 1 broken and splintered laminate on the edges of the door above the kick plate. The bottom half of the bathroom door had an approximately 1/4 inch strip of laminate missing from the edge of the door with rough edges noted. d. Observations of Room 307 on 03/29/16 at 4:10 PM revealed the door of the residents' room had broken and splintered laminate on the edges of the door above and below the door jam. e. Observations of Room 302 on 03/29/16 at 4:20 PM revealed the door of the residents' room had broken and splintered laminate on the edges of the door above and below the door jam. f. Observations of Room 138 on 03/29/16 at 5:42 PM revealed the door of the residents' room had broken and splintered laminate on the edges of the door above and below the door jam. g. Observation of Room 301 on 03/30/16 at 9:01 AM revealed the door of the residents' room had broken and splintered laminate on the edges of the door above and below the door jam. The bottom edge of the bathroom door had broken and splintered laminate. h. Observations of Room 303 on 03/30/16 at 9:48 AM revealed revealed the door of the residents' room had broken and splintered laminate on the edges of the door just above the bottom door hinge. The bottom half of the bathroom door had an approximately 1/4 inch strip of laminate missing from the edge of the door with rough edges noted. i. Observations of Room 134 on 03/30/16 at 11:15 AM revealed the inside of the residents' bathroom	F 253	plungers. This re-education was completed by 4-25-16. To ensure compliance with this requirement the Maintenance Director will randomly inspect 10 Resident Room doors and Bathroom doors weekly for 12 weeks. The Maintenance Director will repair, paint and/or stain doors as needed and identified during these audits. The Maintenance Director and Housekeeping Supervisor will randomly inspect 10 Resident Bathrooms per week for 12 weeks to monitor for appropriate storage of toilet plungers. Opportunities will be corrected as identified by the Maintenance Director and Housekeeping Supervisor. Licensed nurses, Resident Care Specialists, Housekeepers, and department heads were educated by the Administrator regarding correcting dirty resident equipment. Criteria 4 The Maintenance Director will present the results of these audits monthly for 3 months, to the Quality Assurance and Performance Improvement (QAPI) committee The committee will make changes or recommendations as indicated. The Administrator will present the logs concerning dirty equipment at weekly AD HOC meetings for 4 weeks.	

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had broken and splintered laminate on the edges at the bottom half of the door. A quarter-sized hole with splintered edges was noted half way down the inside of the bathroom door.

j. Observations of Room 403 on 03/30/16 at 6:33 PM and 03/31/16 at 12:35 PM revealed the door of the residents' room had broken and splintered laminate on the edges of the bottom half of the door near the hinges.

An interview with the Maintenance Supervisor on 04/01/16 at 3:43 PM revealed he and his assistant painted doors and door frames one day each week but he did not maintain any documentation of the painting. The Maintenance Supervisor further stated the room doors and bathroom doors were constantly being bumped into by wheelchairs and resident care equipment which made it difficult to keep up with painting and repairs.

An interview with the Administrator on 04/01/16 at 3:55 PM revealed she was aware there were some bathroom doors that needed attention but had not compiled of a list of which doors needed repairs.

During an environmental tour on 04/01/16 beginning at 4:04 PM the Maintenance Supervisor and Administrator observed the doors for rooms 134, 138, 224, 227, 301, 302, 303, 304, 307, and 403 with broken and splintered laminate.

An interview was conducted with the Maintenance Supervisor and the Administrator on 04/01/16 at 4:33 PM. The Administrator and Maintenance Supervisor confirmed the doors with broken and

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splintered laminate would need to be repaired and the facility had a Divisional Manager they could consult with regarding repairs.

2. Observations of the smoke prevention doors on 200 hall near Room 227 on 03/29/16 at 1:11 PM revealed the doors had broken and splintered laminate on the edges of the bottom half of the door.

During an environmental tour and interview on 04/01/16 at 4:09 PM the Maintenance Supervisor and Administrator observed the smoke prevention doors on 200 hall near Room 227. The Maintenance Supervisor stated he had caulked and painted the edges of the door a few months ago and was not aware the edges of the door were rough again. The Administrator and the Maintenance Supervisor both stated the smoke prevention doors would be repaired.

3. Observations of the metal door to the nourishment room on the courtyard hall on 03/29/16 at 12:29 PM revealed the door had black scuff marks and scratches over the entire surface of the door.

During an environmental tour and interview on 04/01/16 at 4:01 PM the Maintenance Supervisor and Administrator observed the metal door to the nourishment room on the courtyard hall. The Maintenance Supervisor stated he and his assistant painted doors and door frames one day each week but he did not maintain any documentation of the painting. The Maintenance Supervisor further stated he had missed this door and agreed the door needed to be painted.

4. Observations of Resident #1 on 03/30/16 at

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11:15 AM revealed she was self propelling in the hallway in her wheelchair with her right arm resting in an arm trough. Five areas of dried brown matter the size of a pencil eraser were noted just in front of her right hand on the arm trough. The entire visible surface of the arm trough was covered with a dried white film.

Subsequent observations of Resident #1 on 03/31/16 at 12:49 PM, 03/31/16 at 5:53 PM, and 04/01/16 at 7:15 AM revealed she was self propelling in the hallway in her wheelchair with her right arm resting in an arm trough. Five areas of dried brown matter the size of a pencil eraser were noted just in front of her right hand on the arm trough. The entire visible surface of the arm trough was covered with a dried white film.

An interview was conducted with the Director of Nursing (DON) on 04/01/16 at 11:05 AM. The DON stated the housekeeping department had a schedule for cleaning residents' wheelchairs but she expected the staff to clean the surfaces of residents' wheelchairs anytime they were soiled. The DON observed Resident #1's arm trough on 04/01/16 at 11:08 AM which still had the dried brown matter and dried white film and stated it would be cleaned immediately.

5. Observations of the shared bathroom for rooms 302 and 304 on 03/29/16 at 3:40 PM revealed a plunger on the floor beside to the toilet which was making hissing sound.

Observations of the shared bathroom for rooms 302 and 304 on 03/30/16 at 10:38 AM revealed a plunger on the floor beside the toilet which was making a hissing sound. NA #7 was in room 302 at the time of the observation and was asked if

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F 253	Continued From page 5 the toilet was functioning properly. NA #7 came in the bathroom and proceeded to plunge the toilet and then place the plunger on the floor beside the toilet. Subsequent observations of the shared bathroom for rooms 302 and 304 on 03/31/16 at 8:35 AM and 04/01/16 at 7:15 AM revealed the plunger remained on the floor beside the toilet. During an interview on 04/01/16 at 3:45 PM the Environmental Services Accounts Manager stated the housekeepers should have put the plunger in a bag if it needed to be stored in the residents' bathroom.	F 253		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions;	F 272		4/29/16

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F 272	Continued From page 6 Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to complete a Care Area Assessment that addressed the underlying causes, contributing factors, and risk factors for 3 of 5 residents (Residents #13, #72 and #145) reviewed for psychotropic medication. The findings included: 1. Resident #13 had diagnoses which included, schizophrenia and anxiety disorder. The annual Minimum Data Set (MDS) dated 12/19/15, indicated the resident was moderately cognitively impaired. The MDS also indicated Resident #13 had received antipsychotic and antianxiety medication for 7 of 7 days, and had reported feeling depressed or hopeless during the assessment period.	F 272	Criteria 1 The Resident Care Management Director (RCMD) updated and submitted the Care Area Assessments for Residents #13, #72 and #145 to reflect the Resident's psychosocial well-being, diagnosis, medications, underlying causes, contributing factors, and risk factors as it is related to the Psychotropic Medications prescribed to these Residents by 4-29-16. Criteria 2 All Residents requiring a CAA are at risk for being affected by this alleged deficient practice. The RCMD will review all comprehensive assessments completed during the 30 days prior to 4/4/16 for complete Care Area Assessments. New MDSs will be opened if need is identified	

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F 272	Continued From page 7 Review of Resident #13's Care Area Assessment (CAA) for Psychotropic Drug Use dated 12/19/15, revealed the diagnoses and medications received, but there was no documentation in the summary/analysis of contributing factors, or risk factors related to the care area. The CAA did not indicate if there was any behavior monitoring, adverse drug reaction or attempted dose reductions. The CAA did not indicate if a referral was necessary or if mental health rehab services had seen the resident. Resident #13's Care Plan (most recently updated on 3/30/16) indicated the resident had the potential to be verbally aggressive, resist care, and was at risk for falls. It indicated the problem of Resident 13's verbally aggressive behavior was first addressed in the Care Plan on 9/25/15. On 4/1/16 at 12:03 PM, MDS Coordinator #2 said she thought she had completed the Psychotropic Drug Use CAA summary for Resident #13 and said, "I must not have clicked save on the things that I wrote." During an interview on 4/1/16 at 12:46 PM, the Director of Nursing stated she expected the assessments to be complete for each resident. 2. Resident #72 was admitted to the facility on 2/20/15 and had diagnoses which included, anxiety, major depression, and unspecified psychosis. The annual Minimum Data Set (MDS) dated 2/10/16, indicated the resident was cognitively intact but had exhibited some verbal behavioral symptoms directed toward others. The MDS also indicated Resident #72 had received	F 272	by 4-29-16. Criteria 3 The Resident Care Management Director (RCMD) re-educated the MDS Coordinators and Social Services Director regarding completion of Care Area Assessment related to Psychotropic Medication to include the Resident's psychosocial well-being, diagnosis, medications, underlying causes, contributing factors, and risk factors . This education included instructions on documenting descriptive Care Area Assessments in all areas according to the RAI Manual. The RCMD will randomly audit 10 completed Comprehensive Assessments weekly for 12 weeks to validate descriptive CAAs. Opportunities will be corrected as identified by the RCMD as a result of these audits. Criteria 4 The results of these audits will be presented by the RCMD to the QAPI monthly for 3 months. The committee will make changes or recommendations as needed.	

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antipsychotic, antidepressant and antianxiety medication for 7 of 7 days during the assessment period.

Review of Resident #72's Care Area Assessment (CAA) for Psychotropic Drug Use dated 2/10/16, revealed only the diagnoses and medications received. There was no documentation in the summary/analysis of contributing factors, or risk factors related to the care area. The CAA did not indicate if there was any behavior monitoring, adverse drug reaction or attempted dose reductions. The CAA did not indicate if a referral was necessary or if mental health rehab services had seen the resident.

On 3/29/16 at 12:15 PM, Resident #72 was observed eating lunch in the dining room. She was sitting at a table with other residents and also interacted positively with staff.

During an interview on 4/1/16 at 12:01 PM, MDS Coordinator #2 indicated she was unaware the risk factors and behavior monitoring should be considered for inclusion in the Psychotropic Drug Use CAA summary.

During an interview on 4/1/16 at 12:46 PM, the Director of Nursing stated she expected the assessments to be complete for each resident.

3. Resident #145 was admitted to the facility on 08/10/15 with diagnoses of generalized anxiety disorder, major depressive disorder, and unspecified psychosis.

Record review of nurse's notes on 02/24/16 revealed the Resident's condition had worsened, showing signs of increased confusion, decreased

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F 272	Continued From page 9 energy, and increased inactivity. Review of the Minimum Data Set (MDS) Care Area Assessment (CAA) Summary dated 02/24/16 revealed Resident #145 received scheduled antidepressant and antianxiety medications. Orders were signed on 02/18/16 to place the Resident on Hospice Care with Resident #145 being prescribed additional as needed antidepressant and antianxiety medications. No documentation was noted describing the impact of the prescribed psychotropic medications being used by the resident. Additionally, there were no rationales provided for the care plan decisions/interventions that were put in place. The CAAs failed to identify the Resident's condition, weaknesses, complications, strengths, and overall progress. During an interview on 4/1/16 at 12:01 PM, MDS Coordinator #2 indicated she was unaware the risk factors and behavior monitoring should be considered for inclusion in the Psychotropic Drug Use CAA summary. During an interview on 4/1/16 at 12:46 PM, the Director of Nursing stated she expected the assessments to be complete for each resident.	F 272		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.	F 278		4/29/16

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F 278	Continued From page 10 A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set for 7 of 17 sampled residents (Residents #1, #13, #24 #72, #73, #86, and #157). The findings included: 1. Resident #13 had diagnoses which included, schizophrenia and anxiety disorder. The resident's annual Minimum Data Set (MDS) dated 12/19/15 indicated the resident was not considered by the state Level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness and/or	F 278	Criteria1 The MDS for Resident #1 was corrected by the RCMD to reflect an active diagnosis of Hemiplegia. The MDS for Resident #13 was corrected by the RCMD to accurately reflect the Level II PASRR and the assessment for the Oral/Dental section. The MDSs for Residents #24, #72, #73, #86 and #157 were corrected by the RCMD to accurately reflect the assessments of the Residents for the Oral/Dental section Criteria 2 All Residents have the potential of being	

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F 278	Continued From page 11 intellectual disability. The results of this screening and review are used for formulating a determination of need, determination of an appropriate care setting and a set of recommendations for services to help develop an individual's plan of care. The Oral/Dental assessment section of the MDS was coded as none of the above present, which had questions about broken or ill-fitting dentures, no natural teeth or tooth fragments, abnormal mouth tissue, cavities or broken natural teeth, inflamed or bleeding gums, mouth or face pain, discomfort or difficulty chewing. Because the Oral/Dental section indicated no concerns, the Dental Care Area Assessment (CAA) did not trigger for further assessment. A review of the facility's list of Level II PASRR residents, provided on 3/29/2016, revealed Resident #13 was included among the residents named on the list. During an observation and interview on 3/29/16 at 4:39 PM, Resident #13 indicated she had an upper denture but no natural teeth. On 4/1/16 at 12:01 PM, MDS Coordinator #1 and MDS Coordinator #2 were interviewed. MDS Coordinator #1 indicated she was new to the position and was unsure how the Level II PASRR status was communicated, but that it should be accurate on the MDS. MDS Coordinator #2 indicated she thought if the person had dentures then was not considered edentulous. During an interview on 4/1/16 at 12:46 PM, the Director of Nursing stated she expected the assessments to be accurate for each resident.	F 278	affected by this alleged deficient practice. Criteria 3 The RCMD audited all the MDS Comprehensive Assessments completed during the 30 days before 4/4/16 for accurate coding and corrected as needed. The audit was completed by 4/29/16 and any MDSs that needed to be modified or redone were opened by that date. The RCMD re-educated the MDS Team on accurate coding of all Assessments including the diagnosis of Hemiplegia, Oral/Dental section and Level II PASRR. The re-education was completed by 4-29-16. The RCMD will randomly review 10 Quarterly or Annual MDS assessments weekly for 12 weeks to verify accurate coding of the Resident's status. Opportunities will be corrected as identified by the RCMD. Criteria 4 The RCMD will report the results of this audit to the QAPI Committee at the next 6 meetings. The committee will make changes or recommendations as indicated.	

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2. Resident #72 was admitted to the facility on 2/20/15. The annual Minimum Data Set (MDS) dated 2/10/16, was reviewed. The Oral/Dental assessment section of the MDS was coded as none of the above present, which had questions about broken or ill-fitting dentures, no natural teeth or tooth fragments, abnormal mouth tissue, cavities or broken natural teeth, inflamed or bleeding gums, mouth or face pain, discomfort or difficulty chewing. Because the Oral/Dental section indicated no concerns, the Dental Care Area Assessment (CAA) did not trigger for further assessment.

During an observation and interview on 3/30/16 at 1:56 PM, Resident #72 stated she no longer had any of her own teeth.

On 4/1/16 at 12:01 PM, MDS Coordinator #2 indicated she thought if the person had dentures then was not considered edentulous.

During an interview on 4/1/16 at 12:46 PM, the Director of Nursing stated she expected the assessments to be accurate for each resident.

3. Resident #73 had diagnoses including diabetes mellitus.

Record review of a Dental Care Progress note dated 9/30/13 revealed, "Patient is now edentulous."

Resident #73's annual Minimum Data Set (MDS) dated 7/1/15, was reviewed. The Oral/Dental assessment section of the MDS was coded as none of the above present, which had questions about broken or ill-fitting dentures, no natural

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teeth or tooth fragments, abnormal mouth tissue, cavities or broken natural teeth, inflamed or bleeding gums, mouth or face pain, discomfort or difficulty chewing. Because the Oral/Dental section indicated no concerns, the Dental Care Area Assessment (CAA) did not trigger for further assessment.

On 3/29/16 at 3:45 PM, Resident #73 was in her room. The resident did not have any upper or lower natural teeth and was not wearing dentures.

On 4/1/16 at 12:01 PM, MDS Coordinator #2 indicated she thought if the person had dentures then was not considered edentulous.

During an interview on 4/1/16 at 12:46 PM, the Director of Nursing stated she expected the assessments to be accurate for each resident.

4. Resident #86 was admitted to the facility on 7/6/12. The annual Minimum Data Set (MDS) dated 3/10/16, was reviewed. The Oral/Dental assessment section of the MDS was coded as none of the above present, which had questions about broken or ill-fitting dentures, no natural teeth or tooth fragments, abnormal mouth tissue, cavities or broken natural teeth, inflamed or bleeding gums, mouth or face pain, discomfort or difficulty chewing. Because the Oral/Dental section indicated no concerns, the Dental Care Area Assessment (CAA) did not trigger for further assessment.

On 3/31/16 and 12:06 PM, Resident #86 was observed eating lunch in the dining room. The resident did not have any upper or lower natural teeth and was not wearing dentures.

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On 4/1/16 at 12:01 PM, MDS Coordinator #2 indicated she thought if the person had dentures then was not considered edentulous.

During an interview on 4/1/16 at 12:46 PM, the Director of Nursing stated she expected the assessments to be accurate for each resident.

5. Resident #1 was admitted to the facility on 07/19/13. Review of the medical record revealed hemiplegia was listed as diagnosis.

Review of the annual Minimum Data Set (MDS) dated 11/15/15 revealed hemiplegia was not checked as an active diagnosis.

Review of a care plan dated 02/29/16 revealed Resident #1 had an activities of daily living self-performance deficit related to a stroke, limited range of motion, hemiplegia, limited mobility, and impaired balance. Interventions included a right resting arm trough when up in wheelchair.

Observations of Resident #1 on 03/30/16 at 11:15 AM revealed she was self propelling in the hallway in her wheelchair with her right arm resting in an arm trough. A self gripping strap was observed over her lower right arm which was attached to both sides of the arm trough.

Subsequent observations of Resident #1 on 03/31/16 at 12:49 PM, 03/31/16 at 5:53 PM, and 04/01/16 at 7:15 AM revealed she was self propelling in the hallway in her wheelchair with her right arm resting in an arm trough. A self

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gripping strap was observed over her lower right arm which was attached to both sides of the arm trough.

An interview was conducted MDS Coordinator #1 on 04/01/16 at 2:54 PM. During the interview MDS Coordinator #1 reviewed Resident #1's annual MDS dated 11/15/15 and stated this assessment had been completed by a nurse who worked 2 days a week assisting with MDS assessments. MDS Coordinator #1 confirmed Resident #1's annual MDS should have been coded to include hemiplegia as an active diagnosis. The interview further revealed MDS Coordinator #1 was responsible for reviewing the MDS assessments completed by the nurse who assisted 2 days a week but she could not recall if she had reviewed Resident #1's annual MDS.

6. Resident #24 was admitted on 07/19/14 with diagnoses including dementia and dysphagia.

Review of an annual Minimum Data Set (MDS) dated 06/27/15 revealed Resident #24 was coded in the dental status section as not having and dental problems during the 7-day look back period. Possible options for coding in the dental status section included no natural teeth or tooth fragment(s) (edentulous).

Observations of Resident #24 on 03/31/16 at 9:29 AM revealed the tray card on her meal tray noted she received a pureed diet with nectar thick liquids. No natural teeth were visible at the time of the observation. Nurse Aide #7 was feeding Resident #24 at the time of the observation and confirmed the Resident #24 did not have any teeth.

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An interview was conducted with MDS Coordinator #1 on 04/01/16 at 9:19 AM. During the interview MDS Coordinator #1 reviewed Resident #24's annual MDS dated 06/27/15 and stated this assessment had been completed by a nurse who worked 2 days a week assisting with MDS assessments. MDS Coordinator #1 explained she was not employed by the facility when Resident #24's annual MDS was completed. MDS Coordinator #1 confirmed Resident #24 was edentulous and the annual MDS should have been coded as edentulous in the dental status section.

7. Resident #157 was readmitted to the facility on 02/16/16. Resident #157's most recent Minimum Data Set (MDS) dated 02/23/16 indicated that he was cognitively intact and required total assistance of one staff member for personal hygiene. The MDS did not indicate that Resident #157 did not have any natural teeth or tooth fragments and was edentulous.

Review of admission nursing assessment dated 02/16/16 revealed that Resident #157 had a full set of upper and lower dentures. Edentulous was not checked on this assessment.

Interview with Resident #157 on 03/30/16 at 9:06 AM revealed that he had lost his dentures about 3 weeks ago and he confirmed that he was edentulous. Resident #157 further stated that he had no trouble chewing or swallowing.

Observation of Resident #157 on 03/30/16 at 9:11 AM revealed Resident #157 was edentulous and had no dentures in his mouth.

Observation of Resident #157 on 03/31/16 at

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F 278	Continued From page 17 6:41 PM revealed Resident #157 was edentulous and had no dentures in his mouth. Observation of Resident #157 on 04/01/16 at 9:00 AM revealed Resident #157 was edentulous and had no dentures in his mouth. Interview with MDS Coordinator #1 on 04/01/16 at 12:42 PM revealed that she had 2 other nurses that helped her complete Minimum Data Sets. MDS Coordinator #1 stated that she spot checked their work and then signs off on the assessment. MDS Coordinator #1 further stated when they completed Minimum Data Sets they go and talk to the resident to gather the information needed to complete the assessment. MDS Coordinator #1 confirmed the MDS for Resident #157 should have been coded as edentulous and she would make the correction. On 04/01/16 at 12:46 PM the DON stated she expected the assessments to be complete and accurate for each resident.	F 278		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and resident and staff interviews the facility failed to provide oral care and nail care for 3 of 6	F 312	F312 Criteria 1 Oral Care and Nail care was provided to	4/29/16

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F 312	Continued From page 18 dependent residents reviewed for activities of daily living (Residents #82, #16, and #68). The findings included: 1. Resident #82 was admitted on 05/28/15 with diagnoses including dementia and muscle weakness. Review of the quarterly Minimum Data Set (MDS) dated 01/05/16 revealed Resident #82 had moderately impaired cognition and required extensive assistance with personal hygiene. The quarterly MDS also noted Resident #82 had impaired range of motion of both upper extremities and one lower extremity. Review of a care plan dated 01/11/16 revealed Resident #82 had an activities of daily living self-performance deficit related to dementia, limited mobility, confusion, and a right below the knee amputation. Interventions included: extensive assistance with transfers, gather and provide needed supplies, and provide cueing with tasks as needed. During an interview on 03/30/16 at 9:35 AM Resident #82 stated it had been a while since anyone had assisted her with brushing her teeth. Observations during the interview revealed Resident #82 did not have any top teeth and her bottom teeth were covered with white matter. A follow up interview was conducted with Resident #82 on 03/31/16 at 10:49 AM after she had returned to her room after a group exercise activity. Resident #82 stated no one had assisted her with brushing her teeth last night or this morning. Observations during the interview	F 312	Residents #82, 16 and 68 by the Director of Nursing and Unit Managers on 4/1/16. Criteria 2 Resident requiring assistance with Activities of Daily Living (ADLs) have the potential to be affected by this alleged deficient practice. An audit of Residents requiring assistance with ADLs was completed by the DON, SDC and Unit Managers by 4-29-16 to validate Oral Care and Nail Care was provided as needed. Opportunities were corrected by the DON and Unit Managers as identified. Criteria 3 Nursing Staff were re-educated by Director of Nursing (DON) and Staff Development Coordinator (SDC) on providing assistance with ADLs to include Oral Care and Nail Care. The DON,SDC, andUnit Managers will audit at least 10 residents weekly for 12 weeks to validate completion of Oral Care and Nail Care. Opportunities will be corrected as identified by the DON, SDC and Unit Managers. Criteria 4 The DON will report the results of the audits to the QAPI committee monthly for 3 months. The committee will make changes or recommendations as indicated.	

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revealed Resident #82 did not have any top teeth and her bottom teeth were covered with white matter.

An interview was conducted with Nurse Aide (NA) #5 on 03/31/16 at 2:30 PM. NA #5 confirmed she was assigned to Resident #82 and had washed her up and assisted her out of bed this morning. NA #5 stated she had not brushed Resident #82's teeth this morning because she was in a rush.

Observations of Resident #82's teeth on 04/01/16 at 3:05 PM revealed she did not have any top teeth and her bottom teeth were clean with no white matter noted. NA #6 was interviewed during this observation and stated she had brushed Resident #82's teeth that morning and Resident #82 was cooperative.

During an interview on 04/01/16 at 3:15 PM the Director of Nursing stated she expected NAs to brush residents' teeth while providing morning and evening care.

2. Resident #16 was admitted to the facility on 12/10/2014 with diagnosis which included history of hypertension, anoxic brain damage and osteoarthritis.

Review of the Quarterly Minimum Data Set (MDS) dated 02/23/16 specified Resident #16 had moderately impaired cognition and required extensive assistance with activities of daily (ADL) including personal hygiene.

On 03/29/16 at 10:22 AM Resident #16 was in his room and his mouth was observed and noted to

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have heavy accumulation of white debris covering the surface of and in between all visible teeth. On 03/30/16 at 9:26 AM Resident #16 was observed sitting in his wheelchair in the lobby and noted to have a similar appearance of heavy accumulation of white debris covering the surface of and in between all visible teeth.

On 03/30/16 at 10:19 AM a family interview was conducted. During the interview Resident #16's family member stated that Resident #16 was not capable of brushing his teeth and the staff did not brush his teeth and they should be brushed frequently.

On 04/01/16 at 7:38 AM NA#1 stated she had worked with Resident #16 and was familiar with his care needs. NA#1 stated Resident #16 required extensive assistance with bathing, dressing, personal hygiene and supervision with eating. During the interview, NA#1 stated she had not provided oral care on Resident #16 and she had not offered to provide oral care. She stated she was taught oral care was part of daily care of a resident. NA#1 acknowledge she should have provided oral care.

An interview was conducted on 04/01/16 at 9:42 AM with NA#2. She stated oral care should be offered in the morning before breakfast and in the evening. She further stated, she did not provide oral care because it was her understanding oral care was provided by third shift staff before breakfast and she did not provide or offer Resident #16 oral care.

Interview conducted on 04/01/16 at 11:30 AM with the Director of Nursing (DON). She stated her expectation was that all residents receive oral

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care daily and as frequently as needed.

Interview conducted on 04/01/16 at 11:38 AM with the Administrator and she stated her expectation was for staff to provide oral care daily and as needed.

3. Resident #68 was readmitted to the facility on 03/02/16 with diagnoses diabetes mellitus and partial amputation of foot. Resident #68 most recent minimum data set (MDS) dated 02/06/16 indicated that he was cognitively intact and required extensive assistance of one staff member for personal hygiene. No rejection of care was identified.

Observation of Resident #68 on 03/30/16 at 8:56 AM revealed all 10 fingernails were approximately ¼ inch long and had brown substance under them.

Observation of Resident #68 on 03/31/16 at 8:36 AM revealed all 10 fingernails were approximately ¼ inch long and had brown substance under them.

Observation of Resident #68 on 04/01/16 at 10:43 AM revealed all 10 fingernails were approximately ¼ inch long and had brown substance under them.

Interview with Resident #68 on 03/30/16 at 9:00 AM revealed that he used to trim his own nails but since he had been sick he had not been able to do so. Resident #68 indicated that he had never asked the staff to trim them but they sure needed to be trimmed because they were longer than what he liked.

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F 312	Continued From page 22 Interview with Nursing Assistant (NA) #4 on 04/01/16 at 3:15 PM revealed that she was talking care of Resident #68 and that she was aware his nails needed to be trimmed but stated she had been "running around like a chicken" and had not had time to do it. NA #4 further stated that she had not reported to the nurse that his nails needed to be trimmed. Interview with Director of Nursing (DON) on 04/01/16 at 3:34 PM revealed that nail care should be done anytime that the nails are long or dirty but should routinely be done during the resident shower or bath. The DON further stated that if the resident was a diabetic then the NA should let the nurse know and they would trim them. The DON stated that she expected all NA's to perform nail care during shower or bath or anytime they need it and if the nails were dirty then they should be cleaned and filed.	F 312		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data	F 356		4/29/16

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F 356	Continued From page 23 specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to accurately post the daily staffing sheet for 4 of 4 days of the recertification survey conducted on 03/29/16, 03/30/16, 03/31/16, and 04/01/16. The findings included: Observation made on initial tour of facility on 03/29/16 at 9:00 AM revealed the daily staffing sheet was posted at the entrance of facility and contained the date, the census of the facility, and the actual hours worked for all 3 shifts. The daily staffing sheet for first shift indicated that they had 6 registered nurses (RN), 4 license practical nurses (LPN), 13 nursing assistants (NA), and 2 medication aides (MA). For second shift the daily staffing sheet indicated that they had 2 RN's, 5 LPN's, 16 NA's, and 2 MA's. The daily staffing sheet for third shift indicated that they had 0 RN, 4 LPN's, 13 NA's, and 8 MA's.	F 356	F356 Criteria 1 The Staffing Posting was corrected by the Director of Nursing on 4-2-16. Criteria 2 All residents have the potential to be effected by this alleged deficient practice. Criteria 3 On 4/20/2016 The DON, re-educated the Scheduler on the requirements for Regulation F356 regarding the daily staffing posting requirements and the maintenance and filing of these records. The Scheduler will be responsible for ensuring the staffing positing daily. The DON , SDC or Unit Managers will monitor the posting daily for 7 days, then 3 times a week for 3 weeks, then weekly for 8 weeks to ensure the posting is timely and accurate. Opportunities will be corrected as identified by the DON.	

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F 356	Continued From page 24 Review of the daily assignment sheet dated 03/29/16 indicated that for first shift they had 1 RN, 4 LPN's, 9 NA's, and 1 MA. The daily assignment sheet for second shift indicated that they had 0 RN's, 2 LPN's, 9 NA's, and 2 MA's. The daily assignment sheet for third shift indicated that they had 0 RN, 4 LPN's, 5 NA's, and 0 MA. Observation made of the daily staffing sheet on 03/30/16 at 8:00 AM which was posted at the entrance of the facility and contained the date and actual hours worked for all 3 shift. No census was present on the sheet. For first shift the daily staffing sheet indicated that they had 4 RN's, 5 LPN's, 12 NA's, and 2 MA's. The daily staffing sheet for second shift indicated that they had 0 RN's, 3 LPN's, 11 NA's, and 1 MA. The daily staffing sheet for third shift indicated that they had 0 RN, 3 LPN's, 10 NA's, and 0 MA. Review of the daily assignment sheet dated 03/30/16 indicated that for first shift they had 1 RN, 4 LPN's, 12 NA's, and 2 MA's. The daily assignment sheet for second shift indicated that they had 1 RN, 3 LPN's, 10 NA's, and 1 MA. The daily assignment sheet for third shift indicated that they had 0 RN's, 3 LPN's, 9 NA's, and 0 MA. Observation made of the daily staffing sheet on 03/31/16 at 8:00 AM which was posted at the entrance of the facility contained the date and actual hours worked for all 3 shifts. Census was 130. For first shift the daily staffing sheet indicated that they had 4 RN's, 4 LPN's, 11 NA's, and 2 MA's. The daily staffing sheet for second shift indicated that they had 0 RN, 4 LPN's, 10 NA's, and 1 MA. The daily staffing sheet for third	F 356	Criteria 4 The results of these audits will be reported by the DON to the QAPI committee monthly for 3 months. The committee will recommend further action as needed.	

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	345128	A. BUILDING _____ B. WING _____	C 04/01/2016

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F 356	Continued From page 25	F 356		

shift indicated that they had 0 RN, 3 LPN's, 6 NA's, and 0 MA.

Review of the daily assignment sheet dated 03/31/16 indicated that for first shift they had 1 RN, 3 LPN's, 11 NA's, and 2 MA's. The daily assignment sheet for second shift indicated that they had 0 RN, 4 LPN's, 11 NA's, and 1 MA. The daily assignment sheet for third shift indicated that they had 0 RN, 3 LPN's, 6 NA's, and 0 MA.

Observation made of the daily staff sheet on 04/01/16 at 8:00 AM which was posted at the entrance of the facility contained the date and actual hours worked for all 3 shifts. No census was present on the sheet. For first shift the daily staffing sheet indicated that they had 4 RN's, 5 LPN's, 10 NA's, and 3 MA's. The daily staffing sheet for second shift indicated that they had 2 RN's, 5 LPN's, 10 NA's, and 1 MA. The daily staffing sheet for third shift indicated that they had 0 RN, 3 LPN's, 6 NA's, and 0 MA.

Review of the daily assignment sheet dated 04/01/16 indicated that for first shift they had 1 RN, 4 LPN's, 10 NA's, and 1 MA. The daily assignment sheet for second shift indicated that they had 1 RN, 3 LPN's, 9 NA's, and 1 MA. The daily assignment sheet indicated that they had 0 RN, 3 LPN's, 5 NA's, and 0 MA.

Interview with MA #1 on 04/01/16 at 12:14 PM revealed that she had worked at the facility for 11 years and was responsible for completing the daily staffing sheets up until last Thursday when she was relieved of her duties by the Director of Nursing (DON). MA #1 indicated that she would complete the daily staffing sheets daily by 11:00 AM and would go by the daily assignment sheet

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F 356	Continued From page 26 to report the numbers on the daily staffing sheet. MA #1 also indicated that she only put the nurses and NA's that were direct care staff, the DON or the Minimum Data Set (MDS) nurse were not included in the numbers on the daily staffing sheets. MA #1 further stated that she was never instructed to update the daily staffing sheet as census or staffing changed and on the weekend she would fill them out on Friday and leave them for the weekend staff to hang up. Interview with the DON on 04/01/16 at 4:31 PM confirmed that she had relieved MA #1 of her duties of the completing the daily staffing sheets and was in the process of realigning staff and was not sure who would be completing the daily staffing sheets going forward. The DON stated that she had completed them this week during the survey and was aware that the numbers were incorrect because she was misinformed of which staff was included on the daily staffing sheets. The DON further stated that the expectation was that the daily staffing sheets would be accurate reflection of the direct care staff that was present in the facility throughout the 24 hour period.	F 356		
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	F 431		4/29/16

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F 431	Continued From page 27 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 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 observations and staff interviews the facility failed to remove expired medications from 3 of 4 medication carts and failed to remove expired medication from 1 of 1 central supply closet. The findings included: A review of the facility's policy "Storage and Expiration of Medications, Biologicals, Syringes, and Needles" dated 12/01/07 read in part that the facility should destroy or return all discontinued, outdated/expired, or deteriorated medications or	F 431	Criteria 1 The Director of Nursing discarded all identified expired drugs on 4-2-16. Criteria 2 All residents have the potential to be affected by this alleged deficient practice. An audit of all medication storage rooms, refrigerators and medication carts was conducted and completed by 4-29-16 by the DON, SDC and Unit Managers. All expired and unlabeled items were discarded immediately. Criteria 3	

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F 431	Continued From page 28 biologicals in accordance with Pharmacy return/destruction guidelines. 1 a. Observation of the 200 hall Medication cart 1 on 03/30/16 at 2:00 PM revealed a bottle of Levemir insulin that contained no date indicating when it had been opened. b. Observation of the 100 hall Medication cart 1 on 03/30/16 at 3:45 PM revealed a bottle of ibuprofen that contained an expiration date of 08/15. c. Observation of the Courtyard Medication cart 1 on 04/01/16 at 11:30 AM revealed a bottle of Humalog insulin that had an open date of 03/04/16 and an expiration date of 03/31/16. d. Observation of the central supply closet on 04/01/16 at 2:30 PM revealed 2 bottles of iron elixir that contained an expiration date of 03/16 and a bottle of milk of magnesia that contained an expiration date of 02/15. Interview with Nurse #1 that was responsible for the 200 hall Medication cart 1 on 03/30/16 at 2:00 PM revealed that the she was not aware of when the Levemir was opened and she had no way of knowing if the medication was expired or not. Nurse #1 stated she would discard the insulin and reorder from the pharmacy. Interview with Nurse #2 that was responsible for Courtyard Medication cart 1 on 04/01/16 at 11:30 AM confirmed that Humalog was good for 28 days after being opened and that it had indeed expired on 03/31/16 and should have been discarded.	F 431	The DON re-educated the Central Supply Clerk and Licensed Nurses regarding storage and labeling of medications. This education was completed by 4-29-16. On-going the 3rd shift Nurses will be responsible for the nightly audit of the medication carts for expired meds, Unit Managers will audit the carts weekly and the pharmacy consultant will audit them monthly. The DON, SDC, or a Unit Manager will audit all medication storage rooms and refrigerators weekly to verify medication storage per policy on a on-going basis. Opportunities will be corrected as identified. The Central Supply Clerk has completed an inventory sheet that includes expiration dates for all over-the-counter meds in her supply room. She will check this inventory monthly to discard expired meds timely. Criteria 4 Results of audits and inventories will be presented to the QAPI committee monthly for 3 months by the DON. The committee will make changes or recommendations as indicated.	

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F 431	Continued From page 29 Interview with the central supply clerk on 04/01/16 at 2:52 PM revealed that she received stock twice a week and when she put up the new stock of medications she rotated the new stock to the back of the shelf and pulled what needed to be used first to the front of the shelf. The central supply clerk stated that she had checked the date on the milk of magnesia yesterday and was not sure how she missed it. Interview with the Director of Nursing (DON) on 04/01/16 at 3:39 PM revealed that the third shift nurses were responsible for checking the medication carts nightly looking for expired medications. She also stated that each nurse or medication aide would be expected to check each medication for expiration date prior to administering the medication. The DON reported that the pharmacy staff had been to the building on 03/29/16 and had found some expired medications and removed them. The DON stated nurses were expected to inspect the medication carts for expired medication and return them to the pharmacy per the facility policy.	F 431		
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	F 520		4/29/16

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F 520	Continued From page 30 and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor the interventions the committee put into place in July 2015. This was for two recited deficiencies that were originally cited in June 2015 and subsequently cited in April 2016 on the current recertification survey. The repeated deficiencies were in the area of resident assessment. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: The tags were cross referred to: F 272: Comprehensive Assessment. Based on observations, record review, and resident and staff interviews, the facility failed to complete a	F 520	Criteria 1 Corrective action was accomplished for the alleged deficient practice by the Administrator holding an Ad Hoc QAPI meeting on 4-25-16 to discuss the outcomes of the annual survey and repeat citations of F272 related to Resident Care Area Assessments and F278 related to accurate coding of the MDS. The Interdisciplinary Department Head Team reviewed the previous plans of correction related to accurate CAA and coding for the MDS. Criteria 2 Residents requiring a Comprehensive MDS Assessment are at risk for being affected by this alleged deficient practice. Criteria 3 The RCMD will review all comprehensive assessments completed during the 30 days prior to 4/4/16 for complete Care	

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F 520	Continued From page 31 Care Area Assessment (CAA) that addressed the underlying causes, contributing factors, and risk factors for 3 of 5 residents (Residents #13, #72 and #145) reviewed for psychotropic medication. The facility was recited for F 272 for failing to complete CAAs that addressed the underlying causes, contributing factors, and risk factors for 3 residents reviewed for psychotropic medications. F 272 was originally cited during the June 2015 recertification survey for failing to complete Care Area Assessments that addressed the underlying causes, contributing factors, and risk factors when completing comprehensive MDS assessments 2 residents in the following areas: ADL Functional/Rehabilitation Potential, Psychosocial Well-Being, Behavioral Symptoms, Falls, Nutritional Status, and Pressure Ulcer. F 278: Accuracy of Assessment. Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set for 7 of 17 sampled residents (Residents #1, #13, #24 #72, #73, #86, and #157). The facility was recited for F 278 for failing to accurately code the Minimum Data Set for Preadmission Screening and Resident Review (PASRR), Oral/Dental Status, and Active Diagnoses. F 278 was originally cited during the June 2015 recertification survey for failing to code the Minimum Data Set accurately to reflect Hospice care and Behaviors. During an interview on 04/01/16 at 6:42 PM the Administrator stated accuracy of MDS had not been monitored or discussed in the facility's monthly Quality Assurance meeting since she came to work at the facility the middle of November 2016. The Administrator further stated a corporate representative had been conducting	F 520	Area Assessments. Opportunities for correction were identified and correction was begun by the RCMD by 4-29-16. The Interdisciplinary Department Head Team were re-educated by the Director of Nursing and the Administrator regarding the regulatory requirement for F272 Resident Care Area Assessment and F278 accurate MDS coding. This education was completed by 4-29-16. The Administrator will hold a weekly Ad Hoc QAPI committee meeting for the next 4 weeks to review F272 Resident Care Area Assessment and F278 accurate MDS coding to ensure compliance with these regulations. Opportunities will be corrected as identified. Criteria 4 Measures to ensure that corrections are achieved & sustained include: The results of these weekly meetings will be submitted to the QAPI Committee by the Administrator for review by IDT members at the next 6 meetings. The QAPI committee will evaluate the effectiveness and amend as needed.	

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F 520	Continued From page 32 weekly conference calls with the MDS Coordinators the last month which included a review of MDS assessments for accuracy.	F 520		