STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345331	A. BUILDING _____ B. WING _____	C 06/23/2016

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SARDIS OAKS	5151 SARDIS ROAD CHARLOTTE, NC 28270

(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 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews the facility failed to honor the choice for shower frequency for 2 out of 4 residents sampled (#37 and #13). Findings included: 1. Resident # 37 was admitted on 7/31/16 with diagnoses that included cerebrovascular accident and left side hemiplegia. The quarterly Minimum Data Set (MDS) dated 3/23/16 coded Resident # 37 as cognitively intact and able to make decisions. The MDS indicated that Resident # 37 required extensive assistance with bed mobility, transfers, dressing, toileting and personal hygiene and total dependence with bathing. On 6/21/16 at 9:02 AM an interview was conducted with Resident #37. Resident #37 stated that she had been informed upon admission that residents received two showers per week on scheduled days. Resident #37 stated that she preferred two showers a week but for the past several weeks had only been	F 242	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. Director of Nursing met with Resident #37, to assess shower frequency preference. Director of Nursing met with Resident #13, to assess shower frequency preference. Facility wide audit to be conducted with residents and/or Responsible Party to evaluate shower/bath frequency preferences. Shower/bath schedules will be updated in accordance with each resident's frequency preference. With the annual MDS assessments,	7/21/16

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

Electronically Signed | 07/18/2016

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F 242	Continued From page 1 receiving one shower per week. Review of the facility's Resident Bathing Type report for the period March - June 2016 revealed that Resident #37 was scheduled showers on Tuesdays and Fridays. The report further indicated that Resident #37 had only received one shower per week during the months of May and June. On 6/22/16 at 2:45 PM an interview was conducted with Nurse Aide (NA) #1. NA #1 stated that residents received two showers per week on their scheduled shower days but could request more if they preferred. NA #1 stated that she would ask the resident if they preferred a shower or sponge bath but had never asked if they would like a tub bath. On 6/23/16 at 8:43 AM an interview was conducted with NA #2. NA #2 stated that most residents received two showers per week unless they had requested more. NA #2 stated that on the scheduled shower day, she would ask the resident what type of bath they preferred and would honor their preference. An interview conducted with the Director of Nursing (DON) on 6/23/16 at 8:15 PM revealed that all residents were assessed upon admission in regard to their shower preference and routinely received two showers per week unless they had requested otherwise. DON stated that she was unaware of Resident #37 shower preferences but it was her expectation that she would receive two showers per week. 2) Resident #13 was initially admitted to the	F 242	shower/bath frequency preferences to be reviewed with residents and/or Responsible Party. Shower/bath schedules will be updated in accordance with each resident's frequency preference. Director of Nursing or designee, will conduct weekly 10% audits of residents to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	

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F 242	Continued From page 2	F 242		

facility on 10/22/10 and was re-admitted on 09/20/14 with diagnoses which included high blood pressure, Diabetes Mellitus, and Multiple Sclerosis.

The significant change in status Minimum Data Set (MDS) dated 03/28/16 coded Resident #13 as cognitively intact and able to make her needs known. The MDS indicated Resident #13 required extensive assistance with bed mobility, dressing, eating, and personal hygiene, and was totally dependent on staff for transfers, toileting, and bathing.

On 06/22/16 at 4:30 PM an interview was conducted with Resident #13. Resident #13 stated she had been informed since she was admitted to the facility that the residents received two showers a week on scheduled days. Resident #13 stated she preferred a shower every day or at least 4 times a week. Resident #13 also stated her shower days were on Wednesday and Sunday and she used to get a shower on Friday but that had been discontinued. She further stated "I am lucky to get one shower a week and today is Wednesday and I still have not gotten a shower."

Review of the facility's Resident Bathing Type report dated for March through June 2016 revealed Resident #13 was scheduled showers on Wednesdays and Sundays. The report indicated Resident #13 had only received one shower per week during the month of March, two showers in April, one shower in May, and no showers in June, only bed baths.

On 06/23/16 at 4:54 PM an interview was conducted with Nurse Aide (NA) #3. NA #3 stated

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F 242	Continued From page 3	F 242		

most residents received two showers per week on their scheduled shower days and could request more if they preferred. NA #3 further stated she would ask the resident if they preferred a shower or a bed bath on their scheduled shower days but had not asked if they would like to have a shower or tub bath on any other days.

On 06/23/16 at 4:57 PM an interview was conducted with Nurse Aide #4. NA #4 stated most residents received two showers per week unless they had requested more. NA #4 further stated on the residents scheduled shower day she would ask them what type of bath they preferred and would honor their preference.

On 06/23/16 at 5:25 PM an interview was conducted with Nurse #4. Nurse #4 indicated should a resident request more than 2 showers per week then their preference would be honored. Nurse #4 stated Resident #13 was supposed to have showers at least 2 times a week on Wednesdays 1st shift between 7:00 AM to 3:00 PM and on Fridays 2nd shift between 3:00 PM to 11:00 PM. Nurse #4 confirmed Resident #13 had not received a shower on Wednesday 06/22/16. Nurse #4 stated she was unaware the resident had not received her shower. Nurse #4 further confirmed there was no documentation as to indicate Resident #13 had refused her shower on Wednesday 06/22/16.

On 06/23/16 at 8:15 PM an interview was conducted with the Director of Nursing (DON). The DON stated all residents were assessed upon admission in regards to their shower preferences and the residents routinely received two showers a week. The DON further stated she

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F 242	Continued From page 4 was unaware of Resident #13's shower preferences and it was her expectation should a resident request to have more than 2 showers a week the facility would honor their preference.	F 242		
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; 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.	F 272		7/21/16

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This REQUIREMENT is not met as evidenced by:
Based on record reviews and staff interviews the facility failed to complete Care Area Assessments that addressed underlying causes, contributing factors, and risk factors related to psychotropic drug use for 3 of 5 residents reviewed for unnecessary medication use (Residents #11, #126, and #146).

The findings included:

1. Resident #11 was admitted on 10/08/13 with diagnoses including dementia, depression, and anxiety disorder.

Review of the significant change Minimum Data Set (MDS) dated 02/16/16 revealed Resident #11 was cognitively intact and denied symptoms of depression during the two weeks prior to the assessment date. There were no behavioral symptoms noted on the significant change MDS. The significant change MDS further revealed Resident #11 received antidepressant and antianxiety medications daily during the 7 day assessment period.

Review of Resident #11's Care Area Assessment (CAA) Summary for Psychotropic Medication Use completed on 02/18/16 revealed had diagnoses of depression and anxiety and was prescribed antidepressant and antianxiety medications daily.

Resident #11 Care Area Assessment in the area of Psychotropic Medication Use was reviewed and analyzed by the MDS Coordinator to ensure underlying causes, contributing factors, and risk factors were addressed.

Resident #126 Care Area Assessment in the area of Psychotropic Medication Use was reviewed and analyzed by the MDS Coordinator to ensure underlying causes, contributing factors, and risk factors were addressed.

Resident #146 Care Area Assessment in the area of Psychotropic Medication Use was reviewed and analyzed by the MDS Coordinator to ensure underlying causes, contributing factors, and risk factors were addressed.

MDS Coordinators will be provided education by the Director of Clinical Operations, regarding Federal and State regulation to ensure underlying causes, contributing factors, and risk factors were addressed in the Psychotropic Medication Use Care Area Assessments.

MDS Coordinators will review Care Area

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F 272	Continued From page 6 In addition, it was noted the adverse side effects of the psychotropic medications were predisposing factors for falls and Resident #11's psychotropic medications would be addressed in her care plan for falls. 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 services had seen Resident #11. During an interview on 06/23/16 at 7:32 PM MDS Nurse #1 confirmed she had completed Resident #11's CAA Summary for Psychotropic Medication Use dated 02/18/16. MDS Nurse #1 reviewed the CAA Summary during the interview and stated she did not include specific details regarding Resident #11 because she had not changed in that area when the assessment was completed. MDS Nurse #1 further stated she had focused more on the reasons for the significant change MDS when she completed the assessment and CAA Summaries. An interview was conducted with the Director of Nursing (DON) on 06/23/16 at 8:39 PM. The DON reviewed Resident #11's CAA Summary for Psychotropic Medication Use and stated it could use more resident specific details. The interview further revealed the facility had been auditing MDS assessments and CAA Summaries to be sure details were documented in all of the blocks. 2) Resident #126 was admitted to the facility on 01/23/15 with diagnoses which included epileptic seizures, dementia, major depressive disorder, delusional disorders, hallucinations, and anxiety disorder.	F 272	Assessments for all newly completed comprehensive assessments for July and forward to ensure underlying causes, contributing factors, and risk factors were addressed in the Psychotropic Medication Use Care Area Assessments. Director of Nursing or designee, will conduct weekly 10% audits of the Care Area Assessments to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	

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Review of the annual Minimum Data Set (MDS) dated 01/15/16 revealed Resident #126 was severely cognitively impaired and rejection of care occurred daily with delusions and hallucinations. Further review of the MDS revealed Resident #126 received antipsychotic and antidepressant medications daily during the 7 day assessment period and also received antianxiety medications one day during the 7 day assessment period.

Review of Resident #126's Care Area Assessment (CAA) Summary for Psychotropic Medication Use completed 01/15/16 revealed had diagnoses of seizures and depression and was prescribed antipsychotic, antianxiety, and antidepressant medications daily. In addition, it was noted the adverse side effects of the psychotropic medications were predisposing factors for falls and Resident #126's psychotropic medications would be addressed in her care plan for falls. 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 Resident #126 had a referral to mental health services or a consult or if a referral was necessary.

An interview was conducted on 06/23/16 at 7:10 PM with the MDS Nurse #1. She confirmed she had completed Resident #126's CAA Summary for Psychotropic Medication Use dated 01/15/16. MDS Nurse #1 reviewed the CAA Summary during the interview and stated she did not include specific details regarding Resident #126 because she had not changed in that area when the assessment was completed. The MDS Nurse

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#1 further stated she had focused more on the reasons for the falls when she completed the assessment and CAA summaries.

An interview was conducted on 06/23/16 at 8:15 PM with the Director of Nursing (DON). The DON reviewed Resident #126's CAA Summary for Psychotropic Medication Use and stated it could use more resident specific details. The DON stated the facility had been auditing the MDS assessments and CAA Summaries to be sure details were documented in all of the blocks.

3) Resident #146 was admitted to the facility on 10/29/14 with diagnoses which included history of falls, depression, anxiety, and psychosis.

Review of the significant change Minimum Data Set (MDS) dated 07/06/15 revealed Resident #146 was severely cognitively impaired and no rejection of care. There were no behavioral symptoms noted on the significant change MDS. The significant change MDS further revealed Resident #146 received antianxiety and antidepressant medications daily during the 7 day assessment period.

Review of Resident #146's Care Area Assessment (CAA) Summary for Psychotropic Medication Use completed 07/06/15 revealed had diagnoses of anxiety, increased risk for falls, and depression and was prescribed antianxiety and antidepressant medications daily. In addition, it was noted the adverse side effects of the psychotropic medications were predisposing factors for falls and Resident #146's psychotropic medications would be addressed in her care plan for falls. There was no documentation in the

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F 272	Continued From page 9 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 Resident #146 had a referral to mental health services or a consult or if a referral was necessary. An interview was conducted on 06/23/16 at 7:10 PM with the MDS Nurse #1. She confirmed she had completed Resident #146's CAA Summary for Psychotropic Medication Use dated 07/06/15. MDS Nurse #1 reviewed the CAA Summary during the interview and stated she did not include specific details regarding Resident #146 because she had not changed in that area when the assessment was completed. The MDS Nurse #1 further stated she had focused more on the reasons for the significant change MDS when she completed the assessment and CAA Summaries. An interview was conducted on 06/23/16 at 8:15 PM with the Director of Nursing (DON). The DON reviewed Resident #146's CAA Summary for Psychotropic Medication Use and stated it could use more resident specific details. The DON stated the facility had been auditing the MDS assessments and CAA Summaries to be sure details were documented in all of the blocks.	F 272		
F 278	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		7/21/16

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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 reviews and staff interviews the facility failed to code the Minimum Data Set assessment accurately regarding hearing and speech for 2 of 21 sampled residents (Resident #85 and #295). The findings included: 1. Resident #85 was admitted on 04/08/16. Review of Resident #85's admission Minimum Data Set (MDS) dated 04/15/16 revealed there were dashes instead of numeric responses entered in Section B for Hearing, Hearing Aid,	F 278	Resident #85 MDS Assessment sections of Hearing, Hearing Aid, Speech Clarity, Makes Self Understood, and Ability to Understand Others, were reviewed and analyzed by the MDS Coordinator to ensure accuracy of the resident's assessment. Resident #295 MDS Assessment sections of Hearing, Hearing Aid, Speech Clarity, Makes Self Understood, and Ability to Understand Others, were reviewed and analyzed by the MDS Coordinator to ensure accuracy of the resident's	

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F 278	Continued From page 11 Speech Clarity, Makes Self Understood, and Ability to Understand Others. An interview was conducted with MDS Nurse #1 on 06/23/16 at 7:10 PM. MDS Nurse #1 stated she assessed the resident, reviewed the medical record, and talked with staff when completing her assessment for the MDS. MDS Nurse #1 confirmed she had completed Section B of Resident #85's admission MDS but could not recall specifics of the assessment for Section B. MDS Nurse #1 further stated she entered dashes in the sections for Hearing, Hearing Aid, Speech Clarity, Makes Self Understood, and Ability to Understand Others because there was not a weekly nursing summary completed during the 7 day look-back for her to utilize for supporting documentation. MDS Nurse #1 explained she had been trained to put dashes instead of numeric responses in Section B of the MDS if she did not have weekly nursing summary information available to support her assessment. 2. Resident #295 was admitted on 06/08/16 with diagnoses including cerebrovascular accident (CVA) and right hemiparesis. Review of the admission Minimum Data Set (MDS) dated 06/15/16 revealed Resident #295 was cognitively intact and there were dashes instead of numeric responses entered in Section B for Hearing, Hearing Aid, Speech Clarity, Makes Self Understood, and Ability to Understand Others. An interview was conducted with MDS Nurse #1 on 06/23/16 at 7:24 PM. MDS Nurse #1 stated she assessed the resident, reviewed the medical record, and talked with staff when completing her	F 278	assessment. MDS Coordinators will be provided education by the Director of Clinical Operations, regarding Federal and State regulation to ensure MDS Assessment accuracy in the sections of Hearing, Hearing Aid, Speech Clarity, Makes Self Understood, and Ability to Understand Others. MDS Coordinators will review Care Area Assessments for all newly completed comprehensive assessments for July and forward to ensure MDS Assessment accuracy in the sections of Hearing, Hearing Aid, Speech Clarity, Makes Self Understood, and Ability to Understand Others. Director of Nursing or designee, will conduct weekly 10% audits of the MDS Assessments to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	

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F 278	Continued From page 12 assessment for the MDS. MDS Nurse #1 confirmed she had completed Section B of Resident #295's admission MDS but could not recall specifics of the assessment for Section B. MDS Nurse #1 further stated she entered dashes in the sections for Hearing, Hearing Aid, Speech Clarity, Makes Self Understood, and Ability to Understand Others because there was not a weekly nursing summary completed during the 7 day look-back for her to utilize for supporting documentation. MDS Nurse #1 explained she had been trained to put dashes instead of numeric responses in Section B of the MDS if she did not have weekly nursing summary information available to support her assessment.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		7/21/16

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F 279	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews the facility failed to modify a fall care plan to include updated interventions for 1 out of 3 residents sampled (resident #24) for accidents. Findings Included: Resident #24 was admitted to the facility on 5/6/16 with diagnosis that included fracture of left femur, renal cell carcinoma, stage 4 kidney disease, congestive heart failure, stroke, and atrial fibrillation. An admission Minimum Data Set (MDS) dated 5/13/16 indicated resident #24 was cognitively impaired and was rarely or never understood. The MDS also revealed the resident required extensive, two person assist with activities of daily living, he was not ambulatory, and had a fall in the last month. The Care Area Assessments indicated that the resident was at risk for falls and the staff was to proceed to care plan. A care plan dated 5/26/16 included interventions for fall risk to keep call bell and personal items in reach, assist with ADL needs, keep bed in low position, and wear non-skid socks at all times. A facility report dated 6/9/16 at 10:40 AM revealed Resident #24 had an unwitnessed fall and was found on the floor beside his bed with no injury. The post fall interventions included to have the bed in low position, bed and chair alarms, and increased frequency of monitoring. A nursing note dated 6/9/16 at 11:00 AM indicated resident #24 was observed on the floor in his room with a skin tear on his left forearm. The note revealed a new intervention for frequent rounding	F 279	Resident #24 Care Plan was reviewed by the Interdisciplinary Team and updated with current interventions implemented for the resident. Falls Committee to review Falls Log to ensure care plans were updated with current interventions implemented for each resident. Falls Log updated to include validation that care plans were updated with current interventions implemented for each resident. Facility Educator to provide nursing staff education on Falls Policy/Procedure, with an emphasis on updating care plans with current interventions implemented for each resident. Nurse Supervisor or designee, will conduct weekly 10% audits of the Falls Log to ensure care plans were updated with current interventions implemented for each resident. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	

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F 279	Continued From page 14	F 279		

from nursing assistant and nurse.

A nursing note dated 6/12/16 7:15 AM indicated the night nurse found resident #24 on the floor with skin tears on each elbow.

Another facility report dated 6/12/16 at 7:15 AM indicated Resident #24 had an unwitnessed fall and was found on the floor with skin tears to each elbow. The post fall interventions included to have increased frequency of monitoring, mattress on the floor and personal alarm.

The care plan had no interventions added after the resident ' s falls on 6/9/16 and 6/12/16.

06/22/2016 3:59:55 PM An interview with nurse #1 who was responsible for the care of resident #24 stated after a resident had a fall, the staff were to investigate the fall and follow facility protocol. She went on to say that the nurse was supposed to put a fall intervention in place and write the intervention on the resident ' s care plan.

06/23/2016 8:39:26 AM An interview with nurse #2 indicated that after a resident had a fall, the staff were to follow fall procedure and document fall interventions on the care plan as soon as the fall happened. The nurse revealed she was responsible for the care of resident #24 when he fell on 6/9/16. She also stated that after the fall, interventions were initiated for the staff to round more frequently, and a chair and bed alarm were put in place.

06/23/2016 11:04:14 AM an interview with the DON revealed that the nurses were supposed to update the care plan at the time of a fall and the interventions were reviewed during the morning

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F 279	Continued From page 15 meeting the following day. The DON stated that her expectations were for the care plans to be reviewed and updated with current interventions implemented for the residents. 06/23/2016 11:33:01 AM an interview with the Administrator indicated that after a fall any interventions put in place should be updated on the care plan so all the other staff would be aware of the interventions.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide services by qualified professionals for 1 out of 2 residents sampled (#24). The facility failed to schedule a urology appointment for resident #24 as ordered by the primary care provider. Findings Included: Resident #24 was admitted to the facility on 5/6/16 with diagnosis that included fracture of left femur, renal cell carcinoma, stage 4 kidney disease, congestive heart failure, stroke, and atrial fibrillation. An admission MDS dated 5/13/16 indicated the resident was rarely/never understood, with no behaviors noted or rejection of care. The MDS	F 282	Urology appointment was scheduled for Resident #24. Resident went out for the appointment on 6/27/16. Appointment book was reviewed to ensure each appointment had been scheduled. Appointment Log was developed to include Unit Secretary's signature when order received and appointment scheduled. Facility Educator to provide staff education on new Appointment Log protocol. Nurse Supervisor or designee, will conduct weekly 10% audits of the	7/21/16

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F 282	Continued From page 16 also indicated resident had an indwelling catheter, and was frequently incontinent of bowel. A care plan dated 5/26/16 indicated resident #24 had an indwelling catheter with interventions for indwelling catheter care twice daily, and to offer him fluids during meals, in between meals, and during med pass. A physician telephone order dated 6/9/16 indicated a urology consult for urinary retention and failed voiding trial. 06/22/2016 3:16:48 PM an interview with a unit secretary responsible for making appointments stated after she received an order from the doctor for an appointment, the appointment was supposed to be made immediately. She went on to say the procedure was to make the appointment, log it into the computer, print the sheet off and place in the appointment book. The unit secretary also stated the appointments were written on the board in the resident ' s room. She stated she was supposed to print off a daily appointment schedule and post it in the nursing office to notify staff of upcoming appointments. A book labeled appointments in the nursing office had no urology appointment sheet for resident #24. 06/23/2016 9:58:19 AM an interview with a unit secretary indicated she was not able to find a urology appointment for resident #24. She stated she did not remember the urology order. She went on to say a copy of the order or the appointment was not in appointment book. 06/23/2016 10:48:12 AM the unit secretary stated	F 282	Appointment Log to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	

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F 282	Continued From page 17 resident #24 had not went to the urologist and she scheduled an appointment with a urologist specialist for Monday 6/27/16 at 9:30 AM. 06/23/2016 11:03:41 AM an interview with the DON revealed after the primary care provider wrote an order for an appointment, the unit secretary was supposed to make the appointment, notify staff and place it on the calendar. Her expectations were for the appointments to be made within a week. 06/23/2016 11:34:55 AM an interview with the Administrator indicated his expectations were for an appointment to be made within 2-3 days depending on the urgency of the appt. He further stated the urology appointment scheduled on 6/23/16 for resident #24 was not completed timely for the order written on 6/9/16.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to follow physical therapy recommendations to improve pulmonary function for 1 of 1 sampled residents at risk for recurrent pneumonia (Resident #98).	F 309	Physical therapy reassessed Resident #98 restorative nursing program which included the Restorative Nursing Activities, Frequency, Goals, Plan/Approaches.	7/21/16

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F 309	Continued From page 18 Findings included: Resident # 98 was most recently readmitted on 5/31/16 with diagnoses that included recurrent pneumonia, cerebrovascular accident, hemiplegia, aphasia, and dysphagia. The quarterly Minimum Data Set (MDS) dated 3/25/16 coded Resident #98 as having severely impaired cognition and daily decision making skills. The MDS indicated that Resident #98 required extensive assistance with bed mobility and was totally dependent on staff for locomotion and transfers. A review of physical therapy (PT) discharge notes dated 6/9/16 revealed in part that Resident #98 demonstrated the ability to tolerate sitting in a recliner wheelchair with appropriate alignment for 2 hours. The PT note indicated that staff were " ...educated on the need to have Resident #98 upright out of bed for more often to reduce the risk of aspiration pneumonia from swallowing secretions. Resident #98 ' s quality of life is improved by being able to get into wheelchair ... " A review of the physician orders revealed an order dated 6/9/16 to " discontinue skilled PT and refer to restorative nursing to assist Resident #98 out of bed to a recliner wheelchair 2-3 times per week to assist with respiratory function. " A review of the restorative nursing program referral form from PT recommended a restorative program start date of 6/14/16. The referral indicated a plan for the restorative aide to assist nursing staff with getting Resident #98 out of bed into a recliner wheelchair for up to 2-3 hours, 2-3	F 309	Nurse Supervisor to review Restorative Log, to ensure recommendations from therapy were being followed for each resident in the program. Restorative Nursing Program form to include signatures to certify Restorative Aide training of therapy recommendations and validate oversight of the Restorative Nurse. Therapy Log developed to include resident□s name, date of referral, & description of the restorative program. Nurse Supervisor or designee, will conduct weekly 10% audits of the Therapy Log to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	

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F 309	Continued From page 19	F 309		

times per week, for improved pulmonary function.

A review of the restorative notes revealed no restorative services had been provided since March 2016.

A review of the nurses ' notes for the period May - June 2016 revealed no documentation of resident being out of the bed as recommended by PT.

On 6/21/16 at 9:39 AM Resident #98 was observed in bed asleep with the head of the bed slightly elevated.

On 6/22/16 at 3:24 PM, 5:47 PM and 6:09 PM Resident #98 was observed in bed asleep with the head of the bed slightly elevated.

On 6/23/16 at 9:32 AM Resident #98 was observed in bed with the head of the bed slightly elevated.

An interview on 6/23/16 at 10:07 AM was conducted with Nurse #3 that revealed that staff did assist Resident #98 out of bed into the wheelchair for a few hours at a time but could not recall how often this had occurred.

An interview on 6/23/16 at 3:34 PM was conducted with Nurse Aide #2 (NA #2) that revealed she only assisted Resident #98 out of bed onto a stretcher twice a week for showers.

An interview on 6/23/16 at 4:35 PM with Unit Secretary #2 (US #2) revealed that when a referral for restorative services was received the recommendation was entered into the system and then discussed with staff. US #2 stated that

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F 309	Continued From page 20 for a resident who was totally dependent with transfers, the resident would have been placed on a nursing program instead of restorative for assistance out of bed. US #2 confirmed that no program had been implemented for Resident #98 as recommended by PT. An interview on 6/23/16 at 4:45 PM with the Unit Coordinator revealed that no referral from PT had been entered into the system or restorative services implemented for Resident #98. An interview on 6/23/16 at 5:05 PM with the Director of Rehabilitation (DR) revealed that the intention for the restorative referral for Resident #98 was for the restorative aide to start the therapy program and teach nursing staff the proper positioning of Resident #98 once in the wheelchair. DR stated that when notified by the restorative aide the unit manager would discontinue restorative therapy and implement a nursing program to continue services. An interview was conducted on 6/23/16 at 5:27 PM with the Director of Nursing (DON). DON stated it was her expectation what when that when a restorative referral was received it would be reviewed by the Unit Coordinator, instructions clarified with PT, and entered into the system for implementation. DON stated that a program should have been implemented for Resident #98 as recommended by PT and that her expectation would have been that nurses' document the date/time Resident #98 had been assisted out of bed into the wheelchair.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312		7/21/16

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F 312	Continued From page 21 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 review, and resident and staff interviews the facility failed to provide nail care to 1 of 5 dependent residents reviewed for activities of daily living (Resident #295). The findings included: Resident #295 was admitted on 06/08/16 with diagnoses including cerebrovascular accident (CVA) and right hemiparesis. Review of the admission Minimum Data Set (MDS) dated 06/15/16 revealed Resident #295 was cognitively intact and had functional limitation in range of motion of his upper and lower extremities on one side of his body. The admission MDS noted Resident #295 required limited assistance with personal hygiene and was totally dependent on staff with bathing. The admission MDS indicated rejection of care was not exhibited. Review of the Care Area Assessment (CAA) Summary for Activities of Daily Living (ADL) dated 06/21/16 revealed Resident #295 was admitted for rehabilitation after a CVA with right hemiparesis. The CAA Summary noted Resident #295 had a decline in functional status and needed assistance with bed mobility and toileting.	F 312	Resident #295 nails were clipped and cleaned on 6/23/16. Facility wide observations conducted to ensure facility resident's nails were clipped and clean. Facility Educator to educate nursing staff to provide nail care during am care and as needed. Nurse Supervisor or designee, will conduct random observations weekly, to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	

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F 312	Continued From page 22	F 312		

During an interview on 06/21/16 at 11:10 AM Resident #295 stated he had showers since his admission to the facility but no one had offered to help him cut and clean his fingernails. Resident #295 stated he liked to keep himself groomed and this was not the way he preferred his fingernails to look. Observations during the interview revealed all ten fingernails extended approximately 1/8 to 1/4 of an inch past his fingertips and brown debris was noted under ten fingernails.

Observations of Resident #295 on 06/22/16 at 11:36 AM revealed all ten fingernails extended approximately 1/8 to 1/4 of an inch past his fingertips and brown debris was noted under ten fingernails.

During a follow up interview on 06/22/16 at 3:03 PM Resident #295 stated he had a shower on 06/21/16 but his fingernails were not cleaned or trimmed.

An interview was conducted with Nurse Aide (NA) #1 on 06/23/16 at 2:49 PM. NA #1 stated she typically cleaned residents' fingernails twice a week by soaking them in a basin and then used an orange stick to clean underneath fingernails. NA #1 further stated she filed or trimmed residents' fingernails as needed. NA #1 confirmed she was assigned to Resident #295 on 06/22/16 and 06/23/16 during 7:00 AM to 3:00 PM shift and had not noticed the condition of Resident #295's fingernails on 06/22/16. NA #1 noted Occupational Therapy assisted Resident #295 with his bath on 06/23/16 and she had not noticed the condition of his fingernails on 06/23/16 either.

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F 312	Continued From page 23 Observations of Resident #295 on 06/23/16 at 3:43 PM revealed all ten fingernails extended approximately 1/8 to 1/4 of an inch past his fingertips and brown debris was noted under ten fingernails. An interview with the Director of Nursing (DON) on 06/23/16 at 3:31 PM revealed the NAs were expected to clean and trim residents' fingernails as needed with daily care. The DON stated the facility stocked fingernail files, clippers, orange sticks, and emesis basins for soaking fingernails. The DON further stated NAs could cut residents' fingernails if they were comfortable doing so and if not they were expected to notify the nurse. The DON confirmed Resident #295 would need assistance with cleaning and trimming his fingernails. On 06/23/16 at 5:23 PM the Director of Nursing (DON) was accompanied to Resident #295's room to observe his fingernails and stated all ten fingernails needed cleaning and trimming. The DON could not explain why this had not occurred during his daily care.	F 312		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329		7/21/16

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F 329	Continued From page 24 Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review, observations, and staff interviews, the facility failed to monitor a resident that was on an anti-convulsant medication for epileptic seizures for 1 of 5 sampled residents (Resident #126). The findings included: Resident #126 was admitted to the facility on 01/23/15 with diagnoses which included epileptic seizures, dementia, major depressive disorder, and anxiety disorder. Review of the annual Minimum Data Set (MDS) dated 01/15/16 revealed Resident #126 was severely cognitively impaired and required extensive assistance with bed mobility, dressing, and personal hygiene and was totally dependent on staff for transfers, toileting, and bathing.	F 329	Resident #126 lab was obtained on 6/24/16 and the Dilantin level was 12.1 which was within normal limits. No changes were required to the drug regimen. Lab Log was reviewed to ensure labs were drawn, results were obtained, and appropriate follow-up was conducted, for each resident. Lab Log updated to include receipt of results and appropriate follow-up was conducted, for each resident. Director of Nursing or designee, will conduct weekly 10% audits of the Lab Log to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared	

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F 329	Continued From page 25 Review of a care plan for Resident #126 dated 04/26/16 indicated a knowledge deficit related to current medications. The goal and intervention was to offer Resident #126 or the resident's family a list of the current medications which included Dilantin (an anti-convulsant) used for epileptic seizures. Further review of the care plan indicated an intervention of monitoring and reporting to the physician as needed. Resident #126 drug regimen included Dilantin (phenytoin) for epileptic seizure disorder. A review of a physician's order dated 05/26/16 read in part to obtain a Dilantin level on 05/31/16 which was originally ordered on 05/11/16. A review of the facility laboratory requisition indicated a collection date of 05/18/16 which had a line marked through the date of 05/18/16 and another collection date written for 05/31/16 for a Dilantin (phenytoin) blood level to be drawn on Resident #126. A review of a physician's order dated 06/23/16 read in part to obtain a Dilantin level on 06/24/16. A review of the facility laboratory requisition indicated a collection date of 06/24/16 for a Dilantin (phenytoin) blood level to be drawn on Resident #126. A review of Resident #126's laboratory results indicated no Dilantin (phenytoin) blood levels had been obtained on the following dates of 05/11/16, 05/18/16, or 05/31/16. Resident #126 did have Ammonia blood levels drawn dated 05/31/16, 06/10/16, and 06/13/16 with no indication of a Dilantin blood level being collected.	F 329	with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	

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F 329	Continued From page 26 An interview was conducted on 06/23/16 at 5:00 PM with Nurse #4. Nurse #4 confirmed the physician's orders and laboratory requisitions. Nurse #4 called the laboratory and further confirmed Resident #126's Dilantin level was not obtained and that there was no order in the computer system for a Dilantin level to be drawn for Resident #126 from 05/11/16 through 06/13/16. Nurse #4 stated she was unaware of what happened to the order for Dilantin level or why the level was not obtained. Nurse #4 further stated she would have expected the level to have been drawn as per the physician's original order dated 05/11/16. Nurse #4 obtained a new physician's order dated 06/23/16 for Resident #126 to have a Dilantin level drawn on 06/24/16 and a laboratory requisition was also completed at the same time for the Dilantin level to be collected on 06/24/16. A telephone interview was conducted on 06/23/16 at 7:59 PM with the facility Nurse Pracitioner (NP). The NP stated she would have expected the Dilantin level to have been drawn according to the original date ordered. The NP further stated she was unaware the Dilantin level had not been drawn when previously ordered for Resident #126. An interview was conducted on 06/23/16 at 8:15 PM with the Director of Nursing (DON). The DON stated she was unaware of the blood level not being collected for Resident #126. The DON further stated she would have expected the Dilantin level to have been drawn according to the original date of the physician's order.	F 329		
F 371	483.35(i) FOOD PROCURE,	F 371		7/21/16

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F 371 SS=E	Continued From page 27 STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to properly label and date opened reusable dry food items, and discard of expired food items in the dry storage area. Findings Included: During the initial tour of the dietary department 6/20/16 beginning at 10:28 AM with the area general manager (GM #1) the following items were found to be opened and not labeled or dated in the dry storage area: 1. instant potatoes 2. instant brown gravy 3. grits 4. imitation vanilla flavoring 5. yellow cake mix 6. devil ' s food cake mix 7. Roselli pasta bag. 6/20/16 10:28AM A pack of hamburger buns with " best if used by date " of 6/17/16 was available for use on the bread rack. Also, the following items were found to be not labeled or dated and available for use on the bread rack: 1. 11 hotdog buns wrapped in saran wrap 2. 6 hoagie rolls wrapped in saran wrap.	F 371	The items observed not labeled, dated and/or expired were removed by the Chef Manager on 6/22/16. Food storage areas were observed to ensure items were properly labeled, dated, and if expired, discarded. Chef Manager conducted dietary staff education which included requirements to properly label, date, and discard items, if expired. Shift Supervisor responsibilities to include observing to ensure items were properly labeled, dated, and if expired, discarded. Food Service Supervisor or designee, will conduct random observations weekly, to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a	

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F 371	Continued From page 28 6/20/16 10:28 AM A bin of brown rice was not labeled or dated during the tour and GM #1 removed bin and a dietary worker returned with the bin labeled and dated. An interview with GM #1 immediately following the tour revealed the identified food items were available for use in the cafeteria. GM #1 went on to say that his expectations would be if the staff opened a reusable food item, it would be properly dated, labeled, and wrapped. He added if a food item was expired his expectation was that item would be thrown away. He further stated the procedure for labeling and dating food would be reviewed in the dietary pre-service meeting that day. GM #1 stated the facility was in the process of remodeling the kitchen for more efficient storage. The items found not labeled, dated or expired were removed by GM #1. 06/22/2016 11:37:40 AM A tour of the dietary department with DM #2 revealed banana cake mix opened, wrapped in saran wrap and not dated in the dry storage area. DM #2 stated the food item was available for use in the cafeteria. He went on to say, his expectations were for the reusable food items to be properly labeled and dated after opened. The item was removed from the food storage area by GM#2. 06/23/2016 11:30:34 AM an interview with the Administrator revealed his expectations were for dietary staff to abide by the expiration date on food items in the kitchen. He also stated that reusable dry storage food items would need a label and date after being opened.	F 371	period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET	F 520		7/21/16

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F 520	Continued From page 29 QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident and staff interviews the facility ' s Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in June of 2015. This was for two recited deficiencies which occurred in June of 2015 and on the current recertification survey and complaint investigation. The deficiencies were in the areas of choices and comprehensive	F 520	The facility maintains Quality Assessment and Assurance Committee (QAPI) with members including the Administrator, Director of Nursing, Medical Director, and at least three additional staff from nursing and/or Interdisciplinary team. Corrective Action Plan and plan for monitoring to sustain an effective Quality Assurance Program, to be reviewed with	

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F 520	Continued From page 30 assessments. 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. Findings included: This tag is cross referenced to: 1. a. F 242 Choices: Based on record review, resident and staff interviews the facility failed to honor the choice for shower frequency for 2 of 4 residents sampled (#37 and #13). The facility was recited for F 242 for failure to honor the choice for shower frequency for two residents. F242 was originally cited during the June 2015 recertification survey for failure to assess and honor a resident ' s choice for shower frequency (Resident #31). b. F 272 Comprehensive Assessment: Based on record reviews and staff interviews the facility failed to complete Care Area Assessments (CAA) that addressed underlying causes, contributing factors and risk factors related to psychotropic drug use for 3 of 5 residents reviewed for unnecessary medication use (Residents #11, #26 and #146). The facility was recited for F 272 for failure to include resident specific details in the CAA summaries for psychotropic drug use. F 272 was originally cited during the June 2015 survey for failure to complete analysis of the findings of the CAA ' s that related to urinary incontinence (Resident #156), psychoactive medication (Resident #99), and falls (Resident #178). During an interview on 6/23/16 at 8:45 PM the Administrator stated that a Quality Assessment and Assurance meeting had been held after the recertification survey on 6/4/15 to discuss and develop a plan of action to correct the deficiencies. The Administrator stated that he felt the plan of action developed by the committee	F 520	the QAPI Committee. Corrective Action: F242 Director of Nursing met with Resident #37, to assess shower frequency preference. Director of Nursing met with Resident #13, to assess shower frequency preference. Facility wide audit to be conducted with residents and/or Responsible Party to evaluate shower/bath frequency preferences. Shower/bath schedules will be updated in accordance with each resident's frequency preference. With the annual MDS assessments, shower/bath frequency preferences to be reviewed with residents and/or Responsible Party. Shower/bath schedules will be updated in accordance with each resident's frequency preference. Director of Nursing or designee, will conduct weekly 10% audits of residents to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. Corrective Action: F272 Resident #11 Care Area Assessment in the area of Psychotropic Medication Use	

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F 520	Continued From page 31 had been appropriate and the only thing that could have been done differently to avoid repeat citations would have been to increase the percentage of the sample size audited and monitored.	F 520	was reviewed and analyzed by the MDS Coordinator to ensure underlying causes, contributing factors, and risk factors were addressed. Resident #126 Care Area Assessment in the area of Psychotropic Medication Use was reviewed and analyzed by the MDS Coordinator to ensure underlying causes, contributing factors, and risk factors were addressed. Resident #146 Care Area Assessment in the area of Psychotropic Medication Use was reviewed and analyzed by the MDS Coordinator to ensure underlying causes, contributing factors, and risk factors were addressed. MDS Coordinators will be provided education by the Director of Clinical Operations, regarding Federal and State regulation to ensure underlying causes, contributing factors, and risk factors were addressed in the Psychotropic Medication Use Care Area Assessments. MDS Coordinators will review Care Area Assessments for all newly completed comprehensive assessments for July and forward to ensure underlying causes, contributing factors, and risk factors were addressed in the Psychotropic Medication Use Care Area Assessments. Director of Nursing or designee, will conduct weekly 10% audits of the Care Area Assessments to ensure compliance. Any identified issues will be corrected at	

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F 520	Continued From page 32	F 520	that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	