STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS After review of facility submitted information for dispute of F 325, the team deleted F 325.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157		7/7/16

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

Electronically Signed

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F 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review, staff, dietician, nurse practioner and family interviews the facility failed to inform the nurse practioner and family of significant weight loss for one (Resident #32) of five residents for nutritional review. The findings included: Resident #32 was admitted to the facility on 12/1/2011 with diagnosis of Alzheimer ' s dementia. Review of the " Diagnosis History " included " Protein-calorie malnutrition of moderate and mild degree with an onset date of 11/12/2015. Record review revealed weights as follows: on 05/18/2016 was 133 pounds, on 04/01/2016 was 136 pounds, on 02/01/2016 was 138 pounds and on 12/07/2015 was 154 pounds. The weight loss from December to February represented a significant loss of 16 pounds or 10.3% in 3 months. The weight loss from December to May represented a significant loss of 21 pounds or 12% in six months. Record review revealed no notes by dietary or nursing regarding the weight loss from December to February. The primary physician progress notes dated 12/18/15 and 02/09/2016 indicated no new changes and no new complaints. Resident #32 was treated for bronchitis in February. The progress notes did not address significant weight loss. The annual Minimum Data Set (MDS) dated 2/17/16 indicated resident #32 had long and short term memory impairments, impaired decision	F 157	F □ 157 483.10 Notify of changes (Injury/Decline/Room Change, ETC) 1. Resident #32 responsible party, optum nurse practioner, medical director and contract/corporate specialist have been notified of all recent weights, weight loss, intake and recent approaches to initiate weight stabilization/gain by the director of nursing within the past 6 months on 06/23/2016. 2. The third shift nurses will audit each chart each night to ensure that notification has been made prior to third shift. Any orders/changes that are identified as not complete the third shift nurse will make the director of nursing aware so that he/she may make the notification at that time. 3. All nurses currently employed have been educated on notifying the resident and/or the responsible party, nurse practioner, physician□s assistant, medical director and/or contract/corporate specialist of any changes in the resident condition including but not limited to weight loss/gain, medications, therapy, mental status and physical status by director of nursing on 06/28/2016, 06/29/2016 and 06/30/2016. Nurses were also educated that upon notification the nurse must document in the nurses notes that notification has been completed by director of nursing on 06/28/2016, 06/29/2016 and 06/30/2016. Any nurse who has not completed the notification education prior to 07/01/2016 will be unable to work until he/she has completed	

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F 157	Continued From page 2 making abilities, required total assistance with eating and all activities of daily living and had not had significant weight loss in the last 30 days or 180 days. Review of the care plan dated 2/17/2016 included a problem of potential for alteration in nutrition related to use of mechanical soft diet with pureed meat and required total assistance by staff for meals. The stated goal for this problem included the potential for significant weight loss would be minimized. The approaches for this problem included a " 206 cookie at lunch and supper would be provided, encourage resident to take meals in the dining room, monitor weights and promptly report significant weight loss or developing trend of continued weight loss, and dietician to evaluate current resident nutritional status. Interview on 06/07/2016 at 1:07 PM with a family member revealed she was not aware Resident #32 had a significant weight loss from December to February. Interview via telephone with the registered dietician (RD) on 06/09/2016, at 9:30 AM revealed she visited the facility two times a month and more frequently if necessary. Further interview revealed she had reviewed Resident #32 on 2/10/20/16 and had not made any recommendations at that time. Resident #32 was having gradual weight loss over time. The RD explained reports of her visits were given to the administrator, the director of nursing and the dietary manager. Continued interview revealed the weight she obtained from the medical records in February was 133 pounds. She explained the weights would be located in the hard chart or the	F 157	the notification education. All new employees will be educated on the first day of orientation. 4. Quality Improvement monitoring of 2 random resident charts per hall will take place 5 times weekly for 2 months, then 3 times weekly or 4 weeks, then 1 time weekly for 2 months, then monthly for 2 months to ensure that notification takes place with each change by the Director of nursing, facility administrator or minimal data set nurse. The director of nursing or unit manager/supervisor will immediately retrain the Nurse for any change in which the resident and/or the responsible party, nurse practioner, physician□s assistant, medical director and/or contract/corporate specialist was not made aware. The results of the Quality Improvement monitoring will be reported by the director of nursing or unit manager/supervisor to the Quality Assurance Performance Improvement Committee monthly.	

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electronic chart. During the interview she explained she did not know she had missed a significant weight loss from December to February.

Interview with the Director of Nursing (DON) on 06/09/2016 at 10:18 AM revealed the interventions for weight loss had been ordered as follows: the med pass supplement 4/5/2013, the 206 cookie 10/17/2013, large portions at breakfast 06/09/2015. There were no new interventions since 06/09/2015. The cart nurse would be responsible for informing the physician/Responsible Party of weight loss. She was given weights if there was an "alert " and would review the chart. This was started two weeks ago. The physician would be given a report for recommendations. The DON could not speak to the weight loss that occurred from December to February as she was not the DON during that timeframe. She further explained she had reviewed the medical record and found no documentation the nurse practioner/physician or responsible party had been notified of the significant weight loss.

Interview with Nurse #1 on 06/09/2016 at 11:54 AM revealed the process for weight loss interventions as follows: Significant weights were given to the DON, administrator and RD. Any orders or recommendations would then be made and an order would be written. The nurse would be aware of the weight change and new orders to notify the physician and/or responsible party. The physician would also receive recommendations from the RD.

Interview via telephone on 06/09/2016 at 1:02 PM with the Nurse Practioner (NP) that followed

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Resident #32 revealed she had no documentation or report of a weight loss. She had a weight loss of 3-4 pounds and BMI of 23.44. The NP explained the intake for Resident #32 varied. During the interview, the NP reviewed her records and explained October 2015 was the last time she had a weight in the 150's. She stated the resident " had a weight of 146.3 pounds for December. " The NP further explained the family was aware of the 3-4 pound change. She had a note for May the resident received med pass 2.0, the 206 cookie and Remeron. When asked to clarify about Remeron, she then stated she had a note from February it was discontinued. She was not aware the resident was not eating the 206 cookie, and that had not been communicated to her. During the interview the NP indicated Resident #32 did have end stage dementia and a decline would be expected. She had talked with the family in January about a possible decline. She further explained if she missed a weight loss from December, it " concerned her. " When asked how she received the weights, she explained she obtained the information from the staff/record. She did not get a list from the facility. The resident was a DNR, (Do Not Resuscitate) with no hospitalizations, and she would continue to treat and do labs in the facility.

Interview with the Administrator on 06/0920/16 at 2:05 PM revealed she would have had the weights from December, and weights would be reviewed monthly as well as every 90 days. If the resident was reviewed in the weight meeting a note would have been documented in the IDT notes (Interdisciplinary Team). She stated minutes were kept, and were in the DON's office. She was not sure what the former DON may have done with the notes.

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F 157	Continued From page 5 Interview with the MDS nurse and Social Worker on 06/09/2016 at 2:08 PM revealed the resident was not reviewed in the weight meeting as there were no notes in the computer under IDT. Both staff members explained they did not have anything documented about weight loss.	F 157		
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 and staff interviews the facility failed to allow one resident (Resident #80) a choice about leaving the facility and not applying a wanderguard for one of one residents. The findings included: Resident #80 was admitted to the facility on 7/1/15 with diagnoses of total knee replacement and Parkinson's disease. The admission Minimum Data Set (MDS) dated 7/8/15 assessed the resident as having cognitive impairments due to refusal to answer questions of staff. This MDS indicated he required extensive assistance with most activities of daily living, was able to ambulate in the hall with limited assistance and extensive assistance in his room.	F 242	F □ 242 (483.15) Self-determination □ Right to Make Choices 1. Residents #80 no longer resides in the facility. Current residents residing in the facility with wander guards in place were re-assessed for risk of elopement and cognitive impairment on 6/27/2016 by the unit manager; currently all residents with orders for a wander guard require them per the re-evaluation and elopement risk assessment. All new admits will be assessed for elopement and any resident deemed with the ability to make his/her own decisions will not have a wander guard placed. Any resident showing a decline/improvement in cognition will be re-assessed at that time	7/7/16

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F 242	Continued From page 6 Review of the admission consent forms revealed Resident #80 had signed his MOST form, and the admission forms on 7/1/15. Review of the " Elopement Risk Evaluation " completed on admission revealed Resident #80 was not at risk for elopement. Review of a nurse's note that was dated "late entry" of 8/3/15 for 8/2/15 revealed Resident #80 had stated to the nurse he wanted to leave. He was upset about his girlfriend. He wanted to walk to Rockwell. He had gone to the front door and returned to his room. She had explained about AMA and would get the papers ready for his discharge the next day. A wanderguard had been placed on the resident by the nurse supervisor. Review of the nurse ' s notes for 8/2/15 revealed no information regarding notification of the physician Resident #80 wanted to leave AMA. There were no social worker ' s notes regarding preparation for the resident to leave. Review of the nurse ' s note dated 8/2/15 revealed Resident #80 was last seen at 930 pm and was found to be missing when 11-7 shift came on duty. The police, DON and administrator were notified. The police came to the facility and did a report. Interview with the MDS nurse on 6/8/16 at 2:00 PM revealed Resident #80 had left in the middle of the night. The MDS nurse explained a facility parking lot camera had on video he was behind a bush, two cars came into the parking lot together, and the resident got into one car and that driver got into the other car. The resident drove off in the car. The Social Worker had called Adult	F 242	as well as quarterly and any needed changes will be made with the approval of the interdisciplinary team, resident/responsible party and the resident primary physician/practioner. Resident minimum data set and care plans were updated reflecting the need for wander guard appropriately. 2. Staff nurse, unit manage/supervisor or the Director of Nursing will assess current residents residing in the facility via the facility elopement risk assessment quarterly or upon resident status change and any resident deemed with the ability to make his/her own decisions will not have a wander guard placed. If the elopement deems a resident is cognitively impaired and exhibits exit seeking behaviors; a wander guard will only be placed with the approval of the facility interdisciplinary team, resident/responsible party and the resident□s primary care physician/practioner. New residents will be assessed via the elopement risk assessment upon admission, quarterly or upon resident status change. 3. Education was given to the facility staff by the Director of Nursing on 06/28/2016, 06/29/2016 and 06/30/2016 regarding resident choices, elopement and the need to meet the resident□s cognitive ability with his/her choices. Any resident deemed as minimal to moderate impairment has the right to leave the facility alone or if he/she desires to discharge from the facility against medical advice; he/she may do so at the time of his/her desire by the director of nursing on	

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F 242	Continued From page 7 Protective Services since he left against medical advice. Interview with the Social Worker on 6/8/16 at 2:10 PM revealed When Resident #80 was first admitted, he had a lot of cognitive deficits. He did get better with medication changes. She had called APS the next morning when he had left AMA. She had talked with the resident about Medicaid finances and he was upset and stated he could not live on 30.00 dollars a month. Stated he wanted to leave. Shortly after that conversation, about a week or so, he did leave AMA in the middle of the night. Interview with corporate nurse on 6/8/16 at 3:15 pm revealed she knew Resident #80 and was familiar with the events surrounding his departure from the facility. He opened up more and his cognition changed from the initial impaired memory and decision making skills to moderate impairment with memory. She explained he was not able to answer any question on admission due to medications he had received at the hospital. Per nursing consultant, it would not be the facility policy to apply a wanderguard to a resident that can make their own decisions. It should not have been applied to this resident.	F 242	06/28/2016, 06/29/2016 and 06/30/2016. Any facility staff that has not received the Right to Make Choices education prior to 07/01/2016 will be unable to work until he/she has received the Right to Make Choices education. Any nurse who has not completed the notification education prior to 07/01/2016 will be unable to work until he/she has completed the notification education. All new employees will be educated on the first day of orientation. 4. Residents requiring wander guards will be reviewed weekly in the Patient At Risk meeting. Any resident deemed to require a wander guard that did not have a wander guard previously will be reviewed in the morning meeting Monday through Friday with the department heads. Any issues will be brought to the attention of the director of nursing immediately, should the director of nursing not be present in the facility, the nurse will notify the director of nursing via phone and any resident deemed with the ability to make his/her own decisions will not have a wander guard placed. Any resident showing a decline/improvement in cognition will be re-assessed at that time as well as quarterly and any needed changes will be made with the approval of the interdisciplinary team, resident/responsible party and the resident primary physician/practioner. Should a wander guard be placed unnecessarily The director of nursing will immediately re-educate any staff member/family member/resident on resident choices. Quality Improvement monitoring will be conducted on 3 random	

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F 242	Continued From page 8	F 242	residents daily x4 weeks, then 6 random residents weekly x4 weeks then 6 random residents monthly x4 months by the director of nursing or unit manage/supervisor. The results of the Quality Improvement monitoring will be reported by the director of nursing or unit manager/supervisor to the Quality Assurance Performance Improvement Committee monthly.	
F 253 SS=D	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 observations and staff interviews the facility failed to make repairs to the walls and clean the vents and filters of the heating/air conditioning units for 5 of 39 rooms (Room 202,206,208,210 and 211). Findings included: The following observations were made on 6/6/16 and 6/7/16 during day 1 and day 2 of the recertification survey: A. Room 202- Had no control knobs for the heating/air conditioning unit and pieces of trash in the vent. B. Room 206- Had pieces of trash in the heating/air conditioning unit vent and heavy dust in the filter. C. Room 208- Had pieces of paper trash under the bed, a hole in the wall behind the door approximately 2 inches x 3 inches in size where	F 253	F- 253 483.15 Housekeeping and Maintenance Services 1. Room 202, the control knobs on air conditioner/heating unit were replaced and the vent and filter were vacuumed on 06/09/2016 by the Maintenance Assistant. Room 206, the air conditioner/heating unit vent and filter were vacuumed on 06/09/2016 by the Maintenance Assistant. Room 208, under the bed was swept; the hole behind the door was repaired; the wall beside the sink was repaired; the baseboard was replaced on 06/09/2016 by the Maintenance Assistant. Room 210, the spider web was removed on 06/09/2016 by the housekeeper; the air conditioner/heating unit vent and filter was vacuumed on 06/09/2016 by the	7/7/16

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F 253	Continued From page 9 the door knob touches the wall, the wall on the left side of the sink missing wall paper approximately 3 feet x 2 feet in size and the base board was missing between the sink and the bathroom door. D. Room 210- Had spider webs above the closet and on the privacy curtain rack and the heating/air conditioning unit had small pieces of trash in the vent and heavy dust in the filter. E. Room 211- Had peeling sheetrock on the wall behind the T.V. During an interview with Nurse Aide (NA) #1 on 6/9/16 at 9:40 AM revealed that if there are spills or trash on the floor and it is something that the NA ' s can handle then they will clean it up, otherwise they will get the housekeeper assigned to the floor to take care of it. If an item or equipment is broke and needs repair then a work order is filled out and left in the box at the nurse ' s station. If it is an immediate need then maintenance is paged. An interview with housekeeping aide #1 on 6/9/16 at 9:40 AM indicated that each day the floors in the rooms are swept and mopped around and under the beds. The heating/air conditioning units and window seals wiped. The table tops are cleaned and the bathrooms and toilets are cleaned. On a weekly basis high dusting is completed. The filters in the heating/air conditioning units are brushed out by housekeeping and the vents are cleaned by maintenance. If an item or equipment needs to be repaired then maintenance is notified and a work order is completed and left at the nurse ' s station. During a second observation on 6/9/16 at 10:00 AM with the maintenance director confirmed the following: A. Room 202- Had no control knobs for the	F 253	Maintenance Assistant. Room 211, the sheetrock behind the television was repaired on 06/09/2016 by the Maintenance Assistant. 2. All resident□s rooms have the potential to be effected. 3. All Housekeeping Staff have been educated on proper cleaning techniques with a checklist on 06/05/2016 by the Environmental Services Director and are to sign off after each room is cleaned by the housekeeper assigned to those rooms daily. The Environmental Services Director or Administrator will review check sheets and inspect the resident rooms on the check sheets at minimum three days weekly to determine cleanliness of the rooms x 4 weeks and monthly thereafter. The Department managers will do Guardian Angel rounds 5x weekly to determine rooms in need of repairs. Maintenance work order sheets will be completed. The Environmental Services Director or Administrator will review round sheets and work order sheets weekly for completion of work required. The Air conditioning/heating unit vents and filters will be cleaned weekly and as needed by maintenance personnel x 4 weeks and monthly thereafter. QA monitoring will be completed by the Environmental Services Director or the Administrator. 4. QA Monitoring will be conducted by	

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F 253	Continued From page 10 heating/air conditioning unit and pieces of trash in the vent. B. Room 206- Had pieces of trash in the heating/air conditioning unit vent and heavy dust in the filter. C. Room 208- Had pieces of paper trash under the bed, a hole in the wall behind the door approximately 2 inches x 3 inches in size where the door knob touches the wall, the wall on the left side of the sink missing wall paper approximately 3 feet x 2 feet in size and the base board was missing between the sink and the bathroom door. D. Room 210- Had spider webs above the closet and on the privacy curtain rack and the heating/air conditioning unit had small pieces of trash in the vent and heavy dust in the filter. E. Room 211- Had peeling sheetrock on the wall behind the T.V. An interview with the maintenance director on 6/9/16 at 10:20 AM revealed that he checks for work orders first thing in the morning and at least 10 more times during the day. He further indicated that he cleans the filters and vacuums the vents to the heating/air conditioning unit on a monthly basis. In addition he checks the rooms on a weekly basis, but does not have a check sheet for the rooms. During an interview with the housekeeping director on 6/9/16 at 11:09 AM indicated that she expects rooms to be cleaned each morning and checked throughout the day for spills and trash after meals. She indicated that she uses a check list to check rooms for dust, sweep, mop, trash, toilet paper, paper towels, hand soap blinds, bed side tables and deep cleaning. An interview with the administrator on 6/69/16 at 11:30 AM revealed that her expectations were that rooms are to be checked weekly by	F 253	the Environmental Services Director or the Administrator.	

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	345288	A. BUILDING _____ B. WING _____	06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

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F 253	Continued From page 11 housekeeping and maintenance, any concerns were brought to the quality assurance committee monthly.	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; 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		7/7/16

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F 272	Continued From page 12	F 272		

This REQUIREMENT is not met as evidenced by:
Based on staff interviews and record review the facility failed to identify significant weight loss on the annual Minimum Data Set for Resident #32 for one of five residents with nutritional review.

The findings included:

Resident #32 was admitted to the facility on 12/1/2011 with diagnosis of Alzheimer ' s dementia. Review of the " Diagnosis History " included " Protein-calorie malnutrition of moderate and mild degree with an onset date of 11/12/2015.

Record review revealed weights as follows: on 05/18/2016 was 133 pounds, on 04/01/2016 was 136 pounds, on 02/01/2016 was 138 pounds and on 12/07/2015 154 pounds. The weight loss from December to February represented a significant loss of 16 pounds or 10.3% in 3 months. The weight loss from December to May represented a significant loss of 21 pounds or 12% in six months.

Record review revealed no notes by dietary or nursing regarding the weight loss from December to February.

The annual Minimum Data Set (MDS) dated 2/17/16 indicated resident #32 had long and short term memory impairments, impaired decision

F □ 272 (483.20) Comprehensive Assessments
1. Resident #32 minimum data set was corrected and coded for weight loss on 6/30/2016
2. The director of nursing in coordination with the with the interdisciplinary team will review/assess and correct each resident nursing assessment, minimum data set and care plan for accuracy before the minimum data set nurse submits the resident minimum data set. Each new resident chart will be reviewed by the interdisciplinary team during the am meeting within 24 hours (if resident is admitted on the weekend the chart will be reviewed on the following business day) after admission to ensure that the initial assessment is accurate and complete (without any blanks).
3. Facility Staff (focus on nursing department)were educated on accuracy/completion (all blanks to be filled) of resident assessment in order for minimum data set and care plan to reflect a completed comprehensive assessment by the director of nursing on 06/28/2016, 06/29/2016 and 06/30/2016. Any facility staff that have not been educated prior to 07/01/2016 will be unable to work until he/she has been educated on

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F 272	Continued From page 13 making abilities, required total assistance with eating and all activities of daily living and had not had significant weight loss in the last 30 days or 180 days. The Care area assessments (CAAs) for the annual MDS dated 2/17/16 indicated Resident #32 had functional limitations in her ability to eat, had memory deficits and dementia. The analysis revealed the resident was on a mechanical soft puree meat diet, ate in the dining room, was fed by staff, consumed 50-100% of meals, received a supplement of 2.0 med pass 3 times a day, her weight varied up and down and she did not wear her dentures. Staff would encourage intake of 75 to 100% of meals. This problem would be care planned. Review of the care plan dated 2/17/2016 included a problem of potential for alteration in nutrition related to use of mechanical soft diet with pureed meat and required total assistance by staff for meals. The stated goal for this problem included the potential for significant weight loss would be minimized. The approaches for this problem included a " 206 cookie at lunch and supper would be provided, encourage resident to take meals in the dining room, monitor weights and promptly report significant weight loss or developing trend of continued weight loss, and dietician to evaluate current resident nutritional status. Interview via telephone with the registered dietician (RD) on 06/09/2016, at 9:30 AM revealed she visited the facility two times a month and more frequently if necessary. Further interview revealed she had reviewed Resident #32 2/10/20/16 and had not made any	F 272	accuracy/completion (all blanks to be filled) of resident assessment in order for minimum data set and care plan to reflect a completed comprehensive assessment. All new employees will be educated on the first day of orientation. 4. The director of nursing in coordination with the with the interdisciplinary team will review/assess and correct each resident nursing assessment, minimum data set and care plan for accuracy before the minimum data set nurse submits the resident minimum data set. Any blank/incorrect sections will be corrected/reported to the facility administrator who will then re-educate the department head immediately. Report of the findings will be reported to the interdisciplinary team daily by the director of nursing/unit manager/nurse supervisor or the minimum data set nurse Monday through Friday for 4 weeks, then weekly for 4 weeks, then bi-weekly for 16 weeks. The results of the Quality Improvement monitoring will be reported by the director of nursing or minimal data set nurse to the Quality Assurance Performance Improvement Committee monthly.	

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F 272	Continued From page 14 recommendations at that time. Resident #32 was having gradual weight loss over time. The RD explained reports of her visits were given to the administrator, the director of nursing and the dietary manager. Continued interview revealed the weight she obtained from the medical records in February was 133 pounds. She explained the weights would be located in the hard chart or the electronic chart. During the interview she explained she did not know she had missed a significant weight loss from December to February. Interview with the Administrator on 06/0920/16 at 2:05 PM revealed she would have had the weights from December, and weights would be reviewed monthly as well as every 90 days. If the resident was reviewed in the weight meeting a note would have been documented in the IDT notes (Interdisciplinary Team). She stated minutes were kept, and were in the DON's office. She was not sure what the former DON may have done with the notes. Interview with the MDS nurse and Social Worker on 06/09/2016 at 2:08 PM revealed the resident was not reviewed in the weight meeting as there were no notes in the computer under IDT. Both staff members explained they did not have anything documented about weight loss.	F 272		
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	F 279		7/7/16

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F 279	Continued From page 15 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). This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to care plan 1 of 4 sampled residents reviewed for visual impairment (Resident #79). Findings included: Resident #79 was admitted to the facility on 4/28/16 with diagnoses which included: stage three chronic kidney disease, hyperkalemia, and acute cystitis with hematuria. A review of the Admission MDS (Minimum Data Set) dated 5/05/16 indicated Resident #79 was severely, cognitively impaired and was visually impaired. The Care Area Assessment Summary for Visual Function indicated Resident #79 was able to see	F 279	F □ 279 (483.20) Develop Comprehensive care plans 1. Resident #79 has been care planned for visual impairment on 06/08/2016 with visual impairment by Minimum Data Set Nurse on 06/27/2016 director of nursing clarified orders with opthamologist with diagnoses of cataracts in both eyes, glaucoma both eyes and macular hole in left eye (not a surgical candidate) receiving glaucoma medication on 06/08/2016 and clarified 06/27/2016 with opthamologist of diagnoses and need for glasses. Per opthamologist, resident onle needs over the counter glasses with magnification of 2.50 □ 3.00, which the facility purchased on 06/28/2016 and given to Resident #79. 2. The director of nursing in coordination with the minimum data set nurse will	

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F 279	Continued From page 16 large newspaper headings, but not small print. The Summary revealed that the resident stated his eyeglasses were never mailed to him at the facility. The Summary concluded that a Visual Care Plan was necessary for this resident. Review of an Ophthalmologist Consult dated 5/6/16, revealed Resident #79 was diagnosed with cataracts in both eyes and had pre-glaucoma in both eyes. The recommendation was to restart Travatan-Z (glaucoma medication) in both eyes every evening; and recheck in six months. Review of the medical records revealed no vision care plan was completed for Resident #79. During an observation on 6/8/16 at 2:15pm, Resident #79 was in his wheelchair in his room watching television. The resident was noted to sitting within approximately two feet of the large television screen. During an interview on 6/8/16 at 2:32pm, NA#4 (Nursing Assistant) revealed Resident #79 was alert, oriented and able to make his needs known. She stated that the resident did not wear eyeglasses and never complained of eye problems. The resident never requested a book, magazine, or newspaper; but, preferred to watch television in his room. NA#4 indicated the resident would only leave his room to go to therapy and to eat his meals in the dining room. During an interview on 6/9/16 at 9:25am, the MDS Coordinator confirmed Resident #79's vision impairment was not, but should have been addressed in his Care Plan, at least that he wore eyeglasses.	F 279	review/assess each resident for accuracy of care plans and any updates needed will be addressed and completed by the interdepartmental team during the daily meeting Monday through Friday. 3. Minimum data set nurse and facility staff were educated on the accuracy of comprehensive care plans and updating care plans as needed by the director of nursing on 06/28/2016, 06/29/2016 and 06/30/2016. Any facility staff that have not been educated prior to 07/01/2016 will be unable to work until he/she has been educated on accuracy of care plans. All new employees will be educated on the first day of orientation. 4. The director of nursing/unit manager/nurse supervisor in coordination with the facility administrator will review 3 resident charts daily Monday through Friday for 6 weeks, then 2 resident chart daily Monday through Friday for 6 weeks, then 1 resident chart daily Monday through Friday for 12 weeks. The results of the Quality Improvement monitoring will be reported by the director of nursing or minimal data set nurse to the Quality Assurance Performance Improvement Committee monthly.	

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F 280	Continued From page 17	F 280		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to update a care plan for one (Resident #73) of one residents reviewed for dialysis. The findings included: Resident #73 was readmitted to the facility on 3/7/16 with diagnosis of chronic kidney disease, stage 5 and dependent on hemodialysis. Review of the care plan dated 2/4/16 for a problem of requiring hemodialysis included an approach for IV (intravenous) antibiotic	F 280	F □ 280 (483.20) (483.10) Right to Participate Planning Care □ Revise Care Plan 1. Resident #73 care plan was updated on 06/08/2016 by the minimum data set nurse in coordination with the director of nursing to reflect the discontinuation of antibiotic therapy during dialysis. 2. All residents receiving antibiotic therapy residing in the facility have the potential to be affected. 3. Minimum data set nurse, department	7/7/16

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F 280	Continued From page 18 administered at dialysis due to MRSA/septicemia from temp dialysis port. Review of the Infectious Disease note dated 3/15/16 included orders for IV Vancomycin and Rifampin to be administered with a start date of 2/23/16 and stop date of 3/10/16. Review of the facility March Medication Administration Record (MAR) revealed the medication Vancomycin was administered by dialysis with the stop date of 3/10/16. The Rifampin was administered at the facility as ordered. Interview with MDS nurse on 06/08/2016 at 4:15 PM revealed she had missed deleting the antibiotic use for approaches on the care plan. Further interview revealed copies of telephone orders were used for information to update the care plans.	F 280	heads and facility nurses were educated on the accuracy of comprehensive care plans and updating/changing approaches on resident care plans as needed by the director of nursing on 06/28/2016, 06/29/2016 and 06/30/2016. Any department heads or facility nurses that have not been educated prior to 07/01/2016 will be unable to work until he/she has been educated on accuracy of care plans 4. The minimum data set nurse in coordination with the director of nursing, unit manager/nurse supervisor and staff nurses will update/change approaches of a resident□s care plan via resident□s primary care physician/practioner orders (pink slips {copies of physician/practioner orders}) or at the request of the resident/resident responsible party daily. These updates will be reviewed Monday through Friday in the morning interdisciplinary meeting. Quality Improvement monitoring will be conducted daily by the director of nursing/unit manager/nurse supervisor in coordination with the minimum data set nurse of 5 random resident□s 5x week for 6 months to ensure care plans are accurate with updated/changes approaches. The results of the Quality Improvement monitoring will be reported by the director of nursing/nurse manager or minimal data set nurse to the Quality Assurance Performance Improvement Committee monthly.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		7/7/16

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F 282	Continued From page 19 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to follow the care plan interventions for weight loss for one of five residents with nutrition needs. (Resident #32.) The findings included: Resident #32 was admitted to the facility on 12/1/2011 with diagnosis of Alzheimer ' s dementia. Review of the " Diagnosis History " included " Protein-calorie malnutrition of moderate and mild degree with an onset date of 11/12/2015. The annual Minimum Data Set (MDS) dated 2/17/16 indicated resident #32 had long and short term memory impairments, impaired decision making abilities, required total assistance with eating and all activities of daily living and had not had significant weight loss in the last 30 days or 180 days. The Care area assessments (CAAs) for the annual MDS dated 2/17/16 indicated Resident #32 had functional limitations in her ability to eat, had memory deficits and dementia. The analysis revealed the resident was on a mechanical soft puree meat diet, ate in the dining room, was fed by staff, consumed 50-100% of meals, received a supplement of 2.0 med pass 3 times a day, her weight varied up and down and she did not wear her dentures. Staff would encourage intake of 75	F 282	F 282 483.20 Services by qualified person/per care plan 1. Resident #32 responsible party, optum nurse practioner, medical director and contract/corporate specialist have been notified of all recent weights, weight loss, intake and present care plan interventions and recent order changes to initiate weight stabilization/gain by the director of nursing within the past 6 months on 06/23/2016. The presently employed contract Registered Dietitian's contract will expire on 07/08/2017 and will not be renewed. Triad Group Inc. has employed a Registered Dietitian to begin on 07/01/2016 and is expected in the facility on 07/01/2016 and will continue to return to the facility for monthly visits and as needed to address any resident weight concerns. 2. All residents with the potential for alteration in nutrition residing in the facility have the potential to be affected. 3. Facility staff have been educated on notifying the resident□s nurse, director of nursing or unit manager/nurse supervisor of residents with poor intake and/or lack of consuming nutritional supplements in order for the resident□s nurse, director of nursing or unit manager/nurse supervisor	

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F 282	Continued From page 20 to 100% of meals. This problem would be care planned. Review of the care plan dated 2/17/2016 included a problem of potential for alteration in nutrition related to use of mechanical soft diet with pureed meat and required total assistance by staff for meals. The stated goal for this problem included the potential for significant weight loss would be minimized. The approaches for this problem included a " 206 cookie at lunch and supper would be provided, encourage resident to take meals in the dining room, monitor weights and promptly report significant weight loss or developing trend of continued weight loss, and dietician to evaluate current resident nutritional status. Observations on 06/08/2016 at 1:18 PM revealed resident #32 was fed by nurse aide (NA) #3 in the main dining room. Resident #32 allowed staff to feed her. The 206 cookie was not opened and offered. Resident #3 ate about 50% of the meal. Interview via telephone with the registered dietician (RD) on 06/09/2016, at 9:30 AM revealed she visited the facility two times a month and more frequently if necessary. Further interview revealed she had reviewed Resident #32 on 2/10/20/16 and had not made any recommendations at that time. Resident #32 was having gradual weight loss over time. The RD explained reports of her visits were given to the administrator, the director of nursing and the dietary manager. Continued interview revealed the weight she obtained from the medical records in February was 133 pounds. She explained the weights would be located in the hard chart or the electronic chart. During the interview she	F 282	to notify the resident□s primary physician/practioner, medical director and contract/corporate specialist so that current weight loss/gain may be addressed and the resident minimum data set and care plan interventions may be changed/updated to reflect resident weight loss/gain by the director of nursing on 06/28/2016, 06/29/2016 and 06/30/2016. Any facility staff that have not been educated prior to 07/01/2016 will be unable to work until he/she has been educated on notifying the resident□s nurse, director of nursing or unit manager/nurse supervisor of resident poor intake and/or lack of consuming nutritional supplement. 4. The nurse, nursing assistant or paid feeding assistant responsible for feeding or overseeing any resident meals will notify the resident□s staff nurse of resident poor intake and/or lack of consumption of the resident□s present nutritional supplement in order for the resident□s staff nurse to notify the resident□s primary care physician/practioner for additional orders and to notify the resident/resident□s responsible party of changes. The corporate registered dietitian will be notified of monthly and weekly resident weights gains/losses upon monthly visits and/or as needed for additional approaches/interventions via phone or e-mail by the director of nursing or facility administrator. Quality Improvement monitoring will be conducted weekly in the weekly PAR meeting x6months to ensure that all resident□s with weight loss/gain	

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F 282	Continued From page 21 explained she did not know she had missed a significant weight loss from December to February. Interview with NA#3 on 06/09/2016 at 10:01 AM revealed she was familiar with resident. She explained Resident #32 had to be fed, and she offers the food on the plate first, then the sandwich. NA#3 explained the 206 cookie was a " calorie cookie. " NA#3 stated she would offer the 206 cookie if " she ate all of her food. " Further interview revealed she had forgot to open and offer the cookie. NA#3 explained she should have tried to offer the 206 cookie. Interview with the Director of Nursing on 0/6/092016 at 10:18 AM revealed the cart nurses would be responsible for informing the physician of weight loss. The DON could not speak to the weight loss that occurred from December to February as she was not the DON during that timeframe. Interview via telephone on 06/09/2016 at1:02 PM with the Nurse Practioner (NP) that followed Resident #32 revealed she had no documentation or report of a weight loss.	F 282	have been addressed by the resident□s primary care physician/practioner and the contract/corporate specialist by the facility administrator, director of nursing or the unit manager/nurse supervisor. The results of the Quality Improvement monitoring will be reported by the director of nursing unit manager/nurse supervisor or minimal data set nurse to the Quality Assurance Performance Improvement Committee monthly.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		7/7/16

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F 371	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, facility failed to maintain sanitary conditions in the kitchen by not ensuring: opened food items in storage areas were sealed, dated and labeled, and leftover food items in 1 of 1 walk-in refrigerator were discarded in a timely manner; plates were stacked clean and dry; and, food service equipment and the kitchen floor were maintained clean and free from debris. The facility also failed to prepare and serve turkey croquettes at an acceptable temperature during 1 of 1 meal tray line service observation. Findings included: 1. During the tour of the kitchen on 6/6/16 at 9:32am, an observation of the walk-in refrigerator revealed resealed food items that were not dated and labeled. These food items included: 1-package of sliced, cooked turkey lunch meat; 1-wrapped package of sliced cheese; 1-wrapped package of margarine, 2-packages of mozzarella cheese; 1-large bag of shredded cheese; 1-large bag of parmesan grated cheese; 2-large plastic containers of pimento cheese; and, 2-large containers of egg salad. There was 1-used/opened pouch of whipped topping and 1-unwrapped block of sliced Swiss cheese. The refrigerator also had containers of leftover food items of prepared tuna fish with the handwritten date of 6/1/16 and prepared barbeque with the handwritten date of 5/31/16. The dry foods storage room contained 1-partially, resealed bag	F 371	F- 371 483.35 Food Procure, Store/Prepare/Serve-Sanitary 1. A. Left-over food and dented cans were discarded on 06/09/2016 by the Administrator. B. Kitchen floors, storage cart and food delivery carts were pressure washed by Environmental Services Director on 06/30/2016. The deep fryer, double convection ovens, ice machine filters, knife rack and sharpener, scoops and bulk bins were cleaned by dietary personnel on 06/30/2016. C. The entr¿e was discarded on 06/08/2016 due to the temperature was not within acceptable range. D. Plates were stacked wet. 2. A. Dietary staff were educated on proper repackaging (covering), labeling, dating and discarding items in the refrigerator and dry stock areas by the Administrator on 06/22/2016 and 07/05/2016. B. Dietary staff were educated on proper cleaning procedures on 06/22/2016 and 07/05/2016 by the Administrator. Daily cleaning schedule is posted. When area is cleaned, the dietary personnel will sign off as completed. C. Dietary staff were educated on obtaining proper food temperatures and the ranges acceptable by the Administrator on 06/22/2016 and 07/05/2016. Food Temperatures will be	

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F 371	Continued From page 23 of grits, 1-resealed bag of powdered sugar, and1-resealed bag of gravy mix that were not dated. There was also 2-dented food cans stored on the same shelves with undented food cans in the dry storage room. During an interview on 6/6/16 at 10:22am, the DM (Dietary Manager) revealed all dented cans of foods were stacked on the kitchen's delivery dock and returned to the vendor when new food deliveries were received on Wednesdays. During an interview on 6/9/16 at 1:57pm, the Administrator stated that it was her expectations for leftover food items be discarded after 72 hours. 2. During the food service tray line observation on 6/8/16 at 6:05pm, 16-sectioned plates were stacked wet and/or dirty with brown debris on the preparation table next to the meal tray serving line. The Cook, who was preparing residents' meals on plates, was observed reaching for one of the stacked, sectioned plates. 3. During a tour of the kitchen on 6/6/16 at 10:00am, the kitchen floor was observed covered with dried stains and a black/gray film. There were 3-kitchen transport carts used by the dietary staff to transport food items to and from the storage areas that were dirty with brown crumbs and dried stains. The mixing bowl attached to the uncovered, floor model mixer contained wet/greasy droplets and white particles. When asked, the DM replied the mixer had not been used in over a week. There were large pieces of food items observed in the dark brown grease	F 371	obtained and logged each meal by the cook prior to serving. D. Dietary staff were educated by the Administrator on 06/22/2016 and 07/05/2016 on proper cleaning of all dishes. Dishes are to be clean, dry and free of debris. If wet or debris noted, dishes will not be used but rewashed and air dried. 3. A. A Log will be maintained with items requiring repackaging, labelling and discarding daily and as needed. Dented cans will also be placed on this log and will be maintained by Dietary staff and reviewed by Dietary Manager, Kitchen Supervisor or Administrator. B. A Daily cleaning schedule is maintained by the dietary staff and reviewed by the Dietary Manager, Kitchen Supervisor or Administrator. C. A food temperature log sheet will be placed in the food temperature book for all meals and will be maintained by dietary staff and reviewed by the Dietary Manager, Kitchen Supervisor or Administrator. D. Dishes will be inspected by lead cook prior to meal delivery service beginning. If wet or have debris, will be rewashed and air dried. 4. The Dietary Manager, Kitchen Supervisor or Administrator will review all logs every three days for one month and weekly thereafter for compliance.	

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F 371	Continued From page 24	F 371		

with crumbs in the deep fryer. The deep fryer was stained on the inside and outside walls with a green/brown greasy buildup. The double convection ovens were stained with a buildup of baked on grease covering the outside walls of the ovens and in the opening areas of the oven doors. The 2-front filters of the ice machine contained thick dark gray lint. The sharp knife rack container was sticky to touch as well as the handle on the knife sharpener. A coffee cup was observed flushed in 1 of 3 bins (the sugar bin) of which the lid was sticky with brown particles. There was a large plastic barrel in the dry foods storage room containing several large bags of noodles. The lid covering the barrel was dirty with dried yellowed stains. There was dark gray lint on all of the storage racks in the dry foods storage room.

During a kitchen observation on 6/8/16 at 5:09pm, the kitchen floor was again noted covered with dried stains and a black/gray film.

During the meal tray line observation on 6/8/16 at 5:30pm, 2-open sided delivery carts were dirty with stained brown and white substances.

During an interview on 6/8/16 at 6:30pm, the DM revealed he had been working at the facility for seven weeks and was in the process of making changes including with the dietary staff.

4. During the observation of the meal tray line service in the kitchen on 6/8/16 at 5:35pm, the turkey croquettes had a temperature of 130 degrees Fahrenheit (below the acceptable temperature of 135 degrees Fahrenheit). When questioned, the Cook stated that the proper

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F 371	Continued From page 25 temperature of the hot foods should at least be 135 degrees Fahrenheit or removed from the serving line. However, the Dietary Cook continued plating these turkey croquettes and the dietary staff placed 14-meals containing the turkey croquettes on the delivery cart. When the delivery cart was full of meal trays, the DM (Dietary Manager) indicated the meals were ready for delivery to the main dining room. As it was exiting the kitchen, the meal delivery cart was stopped and the 14-meals containing the turkey croquettes were removed from the cart and the plated turkey croquettes as well as the remaining ones on the serving line were discarded. During an interview on 6/8/16 at 6:30pm, the DM revealed he had been working at the facility for seven weeks and was in the process of making changes including with the dietary staff.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441		7/7/16

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F 441	Continued From page 26 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to track and trend facility infections from March 2016 to June 2016 and staff failed to wash their hands according to infection control guidelines after caring for a resident in isolation (Resident #11) for one of one residents on isolation. The findings included: 1. a. An interview was conducted on 06/09/2016 at 10:46 AM with the Director of Nursing (DON), who began working at the facility on 04/04/2016. The DON explained tracking and trending residents ' infections was completed by the floor nurses. The floor nurses entered infections	F 441	F □ 441 483.65 Infection Control, Prevent Spread, Linens 1. A) All antibiotics/infections for April 2016 and May 2016 were entered into the computer on 06/29/2016 and 06/30/16 by the unit manager. Tracking and trending of infections for April 2016 and May 2016 (no trending of any infections were noted) was completed on 06/30/2016 by the director of nursing and presented to the Interdisciplinary Team during an Improptu Quality Assurance Performance Improvement Committee meeting on	

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F 441	Continued From page 27 under the infection control section of the computerized resident chart. Further explanation provided by the DON indicated she was unable to say if tracking or trending was completed after March 2016. The DON explained she was informed last week of the tracking log in the computer system for the facility. She was "working on it" but it (tracking/trending of infections) had not been done. A copy of the " Infection Log " for the months of January to March 2916 revealed six infections were documented for January, eighteen infections were documented for February and twenty-one infections were documented for March. The number of upper respiratory infections increased from 2 in January to 5 in February and 13 in March. There were 9 urinary tract infections with no cultures obtained to identify pathogens. The report indicated all of the residents had received antibiotics with the infection documented as " resolved. " Review of the report indicated residents had upper respiratory infections in February and again in March with both episodes recorded as " resolved. " A review of the infections for trends was not available for review. An interview with the corporate nurse on 06/09/2016 at 1:14 PM revealed she would expect the DON to track and trend for patterns of infections and do any preventative measures, such as, education of staff. The last DON had left in April 2016. The corporate nurse explained the infection control manual had been emailed to the current DON in the last week. She would expect the floor nurses to continue to do the track/trend on the computer, as that had already been in place. The corporate nurse explained she was not aware the floor nurses did not continue as planned and infections had not been	F 441	07/01/2016 by the director of nursing. B) Resident #11 isolation precautions were discontinued on 06/29/2016 by the Infectious Disease physician. The housekeeping supervisor was discharged from employment on 06/09/2016. 2. A)Infections/antibiotics will be entered into the computer daily by the staff nurse; the director of nursing/unit manager/nurse supervisor will ensure all infections/antibiotics have been entered correctly in order for tracking and trending to be completed by the director of nursing/unit manager (any trending noted will have preventative measures put in place per Centers for Disease Control guidelines). B)Staff will be educated on resident's that have the need for isolation and needed personal protective equipment and hand washing as the need arises per Centers for Disease Control guidelines. 3. A) The Regional Nurse educated the director of nursing on 06/13/2016 regarding tracking and trending infections/antibiotics. B)Facility Staff have been educated on proper hand washing technique and isolation precautions by the director of nursing on 06/28/2016, 06/29/2016 and 06/30/2016. Any facility staff that have not been educated prior to 07/01/2016 will be unable to work until he/she has been educated on proper hand washing technique and isolation precautions. All new employees will be educated on the first day of orientation. Any employees noted not following guidelines set forth by the Center for Disease Control or facility	

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F 441	Continued From page 28 recorded since March 21, 2016. It was further explained the DON and administrator knew how to get the report and were responsible for ensuring the floor nurses were putting the information in the computer to generate the " Infection Log. " A policy and procedure for the infection control program was not available and the corporate nurse explained the facility would follow the CDC guidelines (Center for Disease Control). Interview on 06/09/2016 at 1:58 PM with Nurse #1 revealed the former first shift supervisor was doing the Infection Log in the computer. Further interview revealed she thought the new first shift supervisor was documenting the information. Nurse #1 explained she was not aware the floor nurses were supposed to be entering the information about infections in the computer. The first shift supervisor was not available for interview during the survey. Interview with the Administrator on 06//1609/2016 at 2:01 PM revealed she was not aware the " Infection Log " was not being completed, and was not aware the last posting was 03/21/2016. The Administrator explained she expected the nurses on the floor to complete that task. b. Resident #11 had a contact isolation precaution sign posted on her door. Record review revealed Resident #11 had a diagnosis of MRSA (Methicillin Resistant Staph Aureus) in a knee wound. Review of the physician ' s order dated 05/06/2016 indicated Resident #11 was to be on contact isolation precautions and receivetreatment with intravenous antibiotic Vancomycin.	F 441	will be immediately re-educated. 4. A) Quality Improvement monitoring of any resident with an antibiotic order will be conducted 5x week for 4 weeks, then 3x weekly x8 weeks, then weekly x3 months by the director of nursing/unit manager/nurse supervisor. Tracking and trending will be completed by the director of nursing/unit manager monthly and as needed. The results of the Quality Improvement monitoring will be reported by the director of nursing or unit manager/supervisor to the Quality Assurance Performance Improvement Committee monthly. B)Quality Improvement monitoring of 3 staff members performing proper hand washing will be conducted 5x week for 4 weeks, then 3x weekly x8 weeks, then weekly x3 months by the director of nursing/unit manager/nurse supervisor. Any staff member outside of the handwashing guidelines per the Center for Disease Control or facility will be immediately re-educated. The results of the Quality Improvement monitoring will be reported by the director of nursing or unit manager/supervisor to the Quality Assurance Performance Improvement Committee monthly.	

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Observations on 06/08/2016 at 4:50 PM revealed the environmental director entered resident #11 ' s room. The isolation sign posted on the door indicated staff were to wash their hands upon entering the room and before leaving the room. The environmental director was observed to not wash her hands when she entered the room. She was observed to touch the tray table, and activity items on the tray table. Continuous observations revealed she did not wash her hands after visiting the resident. She left Resident #11 ' s room, touched a resident in the hallway, and went into the day room with other residents. Continued observations revealed she assisted a resident with their shoes in the day room.

Interview with the environmental director on 06/08/2016 at 4:59 PM revealed she did not see the isolation sign on Resident #11 ' s door. During the interview, she asked if she was supposed to do something since Resident #11 was on isolation. This staff member was directed to the charge nurse. Nurse #2 informed the environmental director she would not need to gown or wear gloves. The nurse was interviewed regarding hand washing. Nurse #2 explained staff were to wash their hands when entering and exiting the room. The environmental director explained she had not washed her hands. She provided the explanation she did not see the sign, and could not read it without her glasses. The environmental director explained the sign should be bigger.

Interview on 06/09/2016 at 10:46 AM with the Director of Nursing (DON) revealed staff would be expected to follow the instructions on the isolation

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F 441	Continued From page 30 signs. The staff have been educated on Resident #11's precautions. If staff go into room, can use gown and glove if they want to use it and they are not doing wound care. They should wash their hands before and after being in the resident ' s room.	F 441		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the	F 520	F □ 520 (483.75)	7/7/16

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F 520	Continued From page 31 facility ' s Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these procedures that the committee put into place in July 2015. This was a cited deficiency during a recertification survey on June 2015. The deficiency was in the area of housekeeping and maintenance services. Findings included: This tag is cross referenced to F253-D. Based on observations, record review and staff interviews the facility failed to ensure walls were in repair for 3 of 3 halls (Room # 109,105,104,102,101, 100 208 and 309) that had torn wall paper and holes in the sheet rock. The facility ' s plan implemented on July 2015 indicated that Quality Improvement monitoring to ensure weekly audits to be performed by the department heads during guardian angel rounds 3 times a week for four weeks, then monthly times four months to identify any new maintenance repairs needed. Guardian angel round sheets will be utilized and the department head will fill out repair requisitions as needed for findings. These results will be brought to monthly QA meeting and reviewed. An interview with the Administrator on 6/9/16 at 1:57 PM revealed that the weekly guardian angel checks are still in place and if concerns are noted in the rooms it is corrected that day, we do not wait for the monthly Quality Assurance Committee meeting.	F 520	1. The facility□s Quality Assessment and Assurance committee failed to implement, monitor and revise as needed the action plan developed for the recertification surveys dated July 2015 in order to achieve and sustain compliance. 2. All residents residing in the facility have the potential to be affected. 3. Administrative staff/Interdisciplinary Team member have been educated on 06/28/2016, 06/29/2016 and 06/30/2016 by the facility administrator regarding accurately reporting and revising current action plans as well as developing and implementing a new action plans to ensure state and federal compliance in the facility. Any Administrative staff/Interdisciplinary Team member that have not received the Quality Assessment and Assurance education prior to 06/30/2016 will be unable to work until he/she has received the Quality Assessment and Assurance education. 4. The Administrative staff/Interdisciplinary Team including the facility Medical Director will meet monthly on the third Friday of each month to conduct the facility□s Quality Assessment and Assurance meeting should any interdisciplinary team member find that the facility may need an Impromptu Quality Assessment and Assurance meeting for a facility compliance issue, the administrator will organize a meeting and notify all team members in order for a revision to any present action plan or for a need for a new action plan in order to maintain compliance in the facility. Quality assurance monitoring will take place at	

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F 520	Continued From page 32	F 520	each Quality Assessment and Assurance meeting monthly and any impromptu Quality Assessment and Assurance meeting held. This monitoring tool will be signed off by each Interdisciplinary team member after each meeting accepting and acknowledging all monitoring and revisions set forth by the Quality Assessment and Assurance committee.	