STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345080	A. BUILDING _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB HICKORY VIEWMONT	220 13TH AVENUE PLACE NW HICKORY, NC 28601

(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 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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to notify interested family when the physician discontinued an antipsychotic	F 157	F 157 SS=D Alleged deficient practice in Notify of Changes	8/5/16

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

Electronically Signed | 08/01/2016

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

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F 157	Continued From page 1 medication for 1 of 3 residents. (Resident #116) The findings included: Resident #116 was admitted to the facility on 04/20/15 with diagnoses that included manic depression and bipolar disorder. Review of the most recent quarterly minimum data set (MDS) dated 06/11/16 revealed that Resident #116 was cognitively intact and required extensive assistance of one staff member with bed mobility, transfers and dressing. The MDS further revealed that Resident #116 received no antipsychotic medications during the look back window. Review of pharmacy consultant reported dated 01/29/16 through 2/1/16 read in part Resident #116 had received Risperdal 25 milligram (mg) every night since decreased to that dose on 09/15/15 for diagnosis of bipolar disorder. AT the bottom of the page the physician checked that he accepted the recommendations and the medication was discontinued. The physician signed the report 03/01/16 Review of physician order dated 03/01/16 stated discontinue Risperdal per gradual dose reduction attempt. Signed by Nurse #3. Review of the medical record from 03/01/16 through 06/11/16 revealed no notification to the family that the medication had been discontinued. Interview on 07/07/16 at 12:52 PM with Resident #116's family revealed that she visited almost daily in the evening when she got off from work. The family stated that they kept a journal of things that took place with Resident #116 and back in March 2016 Resident #116 started acting differently for example Resident #116 would talk to the birds and cuss at the family when they would visit. The family requested to see his medication record and discovered that he had not been getting his Risperdal that he had been on	F 157	(Injury/Decline/Room, ETC). 1 .On 07/08/16 The Director of Nursing met with Resident #116 reviewed current medication/ treatment orders and plan of care. Resident voiced understanding. Care Plan arranged with family Member 07/29/2016 2. All Residents have the potential to be affected by the same alleged deficient practice; therefore, The Director of Nursing, Assistant Director of Nursing, and Unit Manager will perform a 100% audit of physician's orders received in the last 14 days to ensure resident, interested family members or responsible parties have been notified of new physician's orders and medication changes. The audit will be completed by 08/05/2016 3. Measures put into place to ensure that the alleged deficient practice does not reoccur include: all licensed nursing staff have been re-educated by the Director of Nursing, Assistant Director of Nursing, and /or Unit Manager on notifying interested family members or responsible parties of all new physician's orders and medication. The education was completed on 07/28/2016 The Unit Manager will audit new	

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F 157	Continued From page 2 for over a year and had done well with. The family stated that they had spoken to the Director of Nursing (DON) about the issue and expressed their concern with the medication being stopped and the family felt like he needed to be on something to control his manic depression and bipolar disorder. In a follow up interview on 07/07/16 at 3:03 PM with Resident #116's family again confirmed that they had not been made aware that Resident #116's Risperdal had been discontinued and they found out when they noticed a change in his behavior and inquired to what medications he was taking. Message left for Nurse #3 on 07/08/16 at 10:53 AM with no return call. Interview with DON on 07/08/16 at 12:39 PM stated that Resident #116 was alert and oriented and confirmed that the family had stopped by her office and wanted to talk about the medication change. The family stated during this visit that they wanted the medication readdressed due to Resident #116's long standing history with manic depression and bipolar disorder and that they had noticed changes with Resident #116 since the medication had been stopped. The DON stated that the Resident #116 was his own responsible party. The DON confirmed that the family visited almost every day and attended most care plan meetings. The DON stated that she had spoken to Resident #116 today and he stated he did not care if his family was notified or not but if they asked questions it was fine for the staff to give them information.	F 157	physician's orders 3xs per week for 4 weeks, then weekly for 8 weeks to ensure interested family or responsible parties have been notified of new orders or medication changes. Corrections will be made daily as opportunities are identified. 4.The results of the audits will be reported by the Director of Nursing in the monthly Quality Assuarance Committee meeting for 3 months and then quarterly the committee will evaluate and make further recommendations as indicated. Date of Compliance: August 05,2016	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities,	F 242		8/5/16

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F 242	Continued From page 3 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 observations, record reviews and resident and staff interviews the facility failed to honor a resident's choice for when to get up in the morning (Resident #70) and failed to provide the number of showers per week according to a resident's choice (Resident #69) for 2 of 5 residents sampled for choices. The findings included: 1. Resident #70 was admitted to the facility on 03/31/16 with diagnoses which included heart disease with atrial fibrillation (irregular heart rate), high blood pressure, diabetes, chronic pain, depression and a stroke. A review of the most recent quarterly Minimum Data Set (MDS) dated 05/05/16 revealed Resident #70 was cognitively intact for daily decision making. The MDS further revealed Resident #70 required extensive assistance with transfers, toileting and hygiene. A review of a facility document titled Resident Preferences Evaluation that was not dated indicated medications would be given according to times agreed upon by the facility and the resident's physician and a section with a question as to whether Resident #70 had any special needs related to the time she received medications was marked N/A (not applicable).	F 242	F242 SS=D Alleged deficient practice in Self- Determination-Right to make choices 1.On 07/08/2016 The Director of Nursing conducted an interview with resident #70 regarding choices specifically including time of medications, time to get out of bed in the mornings, and time to go to bed. No changes were made per residents request and preference sheets were updated. Resident #69 discharged from the facility on 07/05/2016. 2. All residents have the potential to be affected by the same alleged deficient practice; therefore, The Director of Nursing, Assistant Director of Nursing, Unit Assistant, and Unit Manager completed an audit on 07/26/16 on the current resident population to identify that resident choices are updated and honored accordingly.	

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F 242	Continued From page 4 A review of monthly Physician's orders dated 07/01/16 - 07/31/16 indicated Digoxin 125 micrograms (mcg) by mouth daily for a diagnosis of atrial fibrillation. During an interview on 07/06/16 at 9:51 AM with Resident #70 she stated she did not choose when to get up in the morning. She explained the staff woke her up every morning to take a heart pill before 7:00 AM because she had an irregular heartbeat. She stated if she were living at her home she would not get up that early to take the pill. During an observation on 07/0716 at 6:44 AM the door of Resident #70's room was partially open and the lights were on. Resident #70 was up in a wheelchair and was dressed. During an interview on 07/07/16 at 6:45 AM Nurse #5 stated she routinely worked the night shift from 11:00 PM until 7:00 AM. She explained she usually started her medication pass at 5:00 AM in order to give all the medications before she had to give shift report to the day shift nurse. During an interview on 07/07/16 at 7:30 AM Nurse #6 explained she routinely worked on the 11:00 PM to 7:00 AM shift and was assigned to the hall where Resident #70 lived. She stated she usually started her medication pass at 5:00 AM in order to get her medications finished before she had to give report to the day shift nurse. During a follow up interview on 07/08/16 at 2:45 PM Resident #70 stated staff had got her up before 6:00 AM that morning. She stated she	F 242	3.Measures put into place to ensure that the alleged deficient practice does not reoccur include: The Director of Nursing and Social Services Director conducted an in-service/ re-education for all staff regarding the residents' right to make choices consistent with their interests, specifically,honoring times for when to get up in the morning and the number of baths/ showers per week on 7/28/16. Any concerns regarding resident choices will be identified, evaluated and corrected immediately. The Admissions Coordinator meets with residents upon admission to revew choices regarding the residents plan of care. Choices include food likes and dislikes, bathing times, medication times and bedtime schdules. 6 random resident interviews will be conducted per week x 4 weeks, then every other week x 2 months to verify resident choices are being honored. 4.The Administrator will review the minutes from resident council meetings monthly to verify continued compliance with residents rights to make choices involving their care. The Administrator and Director ofNursing will review data obtained during audits, concerns,and rounds; analyze the data and report patterns/trends to the QAPI committee every month for three months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions based on identified trends/ outcomes to ensure continued compliance.	

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had to get up early because everything was on a schedule but when she lived at her home she usually got up between 9:00 AM and 9:30 AM.

During an interview on 07/08/16 at 2:49 PM with Medication Aide #2 who was assigned to give medications to Resident #70 she stated she routinely worked the 7:00 AM to 3:00 PM shift. She confirmed it was documented Resident #70 had received Digoxin 125 mcg at 6:30 AM by the night shift nurse on 07/08/16.

During an interview on 07/08/16 at 5:09 PM the Director of Nursing explained if a resident wanted to sleep later they usually contacted the Physician to see if medication times could be changed. She stated if a resident was being awakened to take medications but wanted to sleep later she would expect for nursing staff to notify the Nurse Practitioner or Physician or put a note in the Physician's communication book so next time they made rounds it could be addressed. She further stated usually medication times could be changed to accommodate the residents' choice. She explained the care plan meetings was their system for residents or family to request a change related to choices and then it was re-evaluated.

2. Resident #69 was admitted to the facility on 07/23/15 with diagnoses which included rheumatoid arthritis, chronic pain, heart disease, chronic lung disease and depression.

A review of the most recent annual Minimum Data Set (MDS) dated 05/13/16 revealed Resident #69 was cognitively intact for daily decision making. The MDS further revealed Resident #69 required extensive assistance by

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staff for hygiene but was totally dependent on staff for bathing, was frequently incontinent of bladder and always incontinent of bowel.

A review of a care plan titled activities of daily living (ADL) dated 05/25/16 revealed Resident #69 required extensive assistance by 1 staff member for completion of ADL needs. The goals were listed to have ADL needs met with staff assistance while maintaining the highest level of independent function possible. The approaches were listed in part to gather and provide needed supplies, allow Resident #69 adequate time to complete tasks, encourage active participation in tasks, praise all efforts, provide cueing with tasks as needed and provide individual education as needed.

A review of a facility document titled Resident Preferences Evaluation that was not dated indicated showers 3 times a week for Resident #69.

A review of facility documents labeled bath detail report and bath worksheets revealed Resident #69 received baths and showers as follows:
06/08/16 (Tuesday) bed bath
06/10/16 (Friday) shower
06/12/16 (Sunday) shower
06/14/16 (Tuesday) shower
06/17/16 (Friday) bed bath
06/19/16 (Sunday) bed bath
06/21/16 (Tuesday) bed bath
06/24/16 (Friday) shower
06/26/16 (Sunday) shower
06/28/16 (Tuesday) shower

There were no reports available for July regarding showers.

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F 242	Continued From page 7 During an interview on 07/05/16 at 11:36 AM Resident #69 stated he preferred to get 3 showers a week. He explained he had talked with staff and requested 3 showers a week but staff gave him bed baths instead because that took less time. He stated he did not like to take bed baths but preferred showers instead. During an interview on 07/07/16 at 3:22 PM Nurse #4 explained the Nurse Aides (NAs) assigned to each hall gave showers to residents. She stated showers were given twice a week and were scheduled according to room number for day of week and for first or second shift. She further stated sometimes NAs gave bed baths instead of showers because of the workload they had to complete on their shift. During an interview on 07/08/16 at 5:09 PM the Director of Nursing explained the bath work sheets were a tool the NAs used to fill out when they offered resident's baths or showers. She stated she expected for NAs to communicate with the nurse when resident's refused baths or showers so it could be documented. She explained the Admissions Coordinator usually asked the resident or their family what their bath preferences were when they were admitted to the facility. She further explained the care plan meetings was their system for re-evaluation of choices for baths and showers and if a resident or family requested more showers their choices should be honored. She stated there were no reports of showers or baths documented for Resident #69 for July 2016.	F 242		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES	F 246		8/5/16

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F 246	Continued From page 8 A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review the facility failed to identify and make accommodations for a resident with a visual impairment for 1 of 1 sampled resident (Resident #168). The findings included: Resident #168 was admitted to the facility on 06/23/16 with diagnoses that included macular degeneration, glaucoma and others. A documented titled "Nursing Admission Intake Form" dated 06/23/16 completed by Nurse #2 specified the resident's vision was "adequate" and the resident was diagnosed with macular degeneration. An activity assessment dated 06/29/16 completed by the Activity Director specified reading materials were not important at all to the resident because of "poor eyesight." The admission Minimum Data Set (MDS) dated 06/30/16 specified the resident's vision was adequate, her cognition was intact and she required extensive assistance with activities of daily living and her active diagnoses included macular degeneration. On 07/05/16 at 3:50 PM Resident #168 was	F 246	F246 SS=D Alleged deficient practice in Reasonable Accomodation of Needs/ Preferences 1.On 07/07/16 the Director of Nursing Met with resident #168 to review visual challenges and complete a vision assessment. On 07/07/16 red tape was added to resident #168 call light to accommodate her needs and per her preference. 2. All residents have the potential to be affected by the same alleged deficient practice; therefore, The Director of Nursing, Assistant Director of Nursing, and Unit Manager completed an audit on 07/26/16 on the current resident population to identify that preferences are updated,and accommodations are honored accordingly. 3. Measures put into place to ensure that the alleged deficient practice does not reoccur include: The Director of Nursing and Social Services Director conducted	

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F 246	Continued From page 9 interviewed in her room. She was asked about the cleanliness of her room and stated, "I assume it's clean because I can't see very well. I am blind in one eye and don't see well out of my other eye." During the interview the resident wore glasses and was seated in her wheelchair positioned beside the bed. Resident #168's call bell was a gray handle attached to a gray cord attached to the wall. The cord was noted to be behind the resident and the call bell was laying in the bed. Resident #168 was asked if she could reach her call bell and she turned and asked, "Where is it?" Resident #168 stated that she had difficulty seeing her call bell because the bell was a similar color to the sheets on her bed making it difficult for her to find. She explained that she often relied on her roommate to call for assistance because she was not always able to see her call bell to call for assistance. She said she was fearful because her roommate was being discharged soon and worried what she would do for help without her roommate. Resident #168 added that with her visual impairment she would be able to see the bell better if it was red providing a visual contrast. Resident #168 went on to explain that her eyesight varied depending on contrast, lighting, shapes and sizes. She stated that no one in the facility had asked her about her eyesight or offered to make accommodations for her. A care plan dated 07/06/16 for a visual impairment identified approaches that included: Ensure large print reading materials were available - Announce self when entering room - Keep room and pathway free from clutter - Keep most often used items in reach	F 246	an in-service/re-education for all staff regarding the residents' right to make choices consistent with their interests, specifically,honoring reasonable accommodation of needs/preferences, except when the health or safety of the resident or another resident would be endangered on 7/28/16. The Administrator will review concerns during morning stand up meeting to identify opportunities related to providing resident choices, accommodations, preferences and ensure timely follow-up. The Admissions Coordinator completes a comprehensive preference worksheet upon admission. Resident interviews will be conducted randomly on 6 residents per week for 4 weeks, then 6 residents every other week for 2 months to include questions regarding request/accommodation of needs/preferences. The Administrator will review the minutes from resident council monthly to identify concerns related to accommodations of needs/ preferences and provide a timely response to ensure continued compliance. 4. The Administrator and Director of Nursing will review data obtained during preference audits, concerns, and rounds; analyze the data and report patterns/trends to the QAPI committee every month for three months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions based on identified trends/ outcomes to ensure continued compliance.	

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On 07/07/16 at 9:05 AM observations of Resident #168 being served breakfast in her room were made. The staff member placed the tray down, removed the dome lid, asked the resident if she needed anything and Resident #168 replied, "yes, I need you to tell me what it is I am eating I can't see the food to identify what's on my tray." The staff member oriented the resident to her breakfast tray and where each item was located.

On 07/07/16 at 9:07 AM nurse aide (NA) #1 was interviewed and stated that Resident #168 had told her she "could not see everything."

On 07/07/16 at 9:30 AM observations were made of Resident #168 receiving medication from medication technician #1. The medication technician had to explain to the resident which clear plastic cup was her drinking cup and which plastic cup was for her to rinse her mouth out and spit after taking an inhaled medication. The medication technician was interviewed about the resident not being able to distinguish her call bell and replied she tried to always keep it in reach.

On 07/07/16 at 3:52 PM NA #2 stated, "I didn't know until yesterday she (Resident #168) couldn't see well."

On 07/08/16 at 9:00 AM Resident #168's call bell was wrapped in red electric tape. Resident #168 was interviewed and stated she was able to find the call bell.

On 07/08/16 at 10:00 AM the Director of Nursing (DON) was interviewed and explained that Resident #168 showed no signs of not being able to see, stating, and "She has read my name badge." She added Resident #168 tried to gain

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(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 246	Continued From page 11 sympathy from staff at times. The DON reported that she would expect staff to make accommodations for residents but felt Resident #168 had demonstrated her vision to be adequate.	F 246		
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 repair stained sinks in 2 resident bathrooms on 1 of 4 resident hallways (Room #410 and #411) and failed to repair a damaged wall in 1 resident room (Room #208) on 1 of 4 resident hallways. The findings included: 1. a. Observations in the bathroom of room #410 on 07/05/16 at 11:48 AM revealed a dark brown stain around the drain of the sink in the bathroom. Observations in the bathroom of room #410 on 07/07/16 at 4:54 PM revealed a dark brown stain around the drain of the sink in the bathroom. Observations in the bathroom of room #410 on 07/08/16 at 4:09 PM revealed a dark brown stain around the drain of the sink in the bathroom. b. Observations in the bathroom of room #411 on 07/05/16 at 4:00 PM revealed dark brown stains and rough edges to the touch around the overflow drain in the sink in the bathroom.	F 253	F253 SS=D Alleged deficient practice In Housekeeping & Maintenance Services 1.On 07/12/2016 the Maintenance Director installed new sinks in the bathrooms of room #410,and room #411. On 07/08/2016 the Maintenance Director repaired the wall in room #208. 2.All residents have the potential to be affected by the same alleged deficient practice; therefore, The Administrator, The Admissions Coordinator, The Maintenance Director,and Housekeeping Director have completed 100% audit of all patient rooms on 07/11/2016. Corrections/plans made for findings. Audit included checking walls to ensure proper condition of resident rooms and bathrooms including inspection of sinks for staining.	8/5/16

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F 253	Continued From page 12 Observations in the bathroom of room #411 on 07/07/16 at 4:53 PM revealed dark brown stains and rough edges to the touch around the overflow drain in the sink in the bathroom. Observations in the bathroom of room #411 on 07/08/16 at 4:10 PM revealed dark brown stains and rough edges to the touch around the overflow drain in the sink in the bathroom. 2. Observations in room #208 on 07/06/16 at 8:52 AM revealed 6 holes punched into the dry wall with gashes through the dry wall next to bed A. Observations in room #208 on 07/07/16 at 4:50 PM revealed 6 holes punched into the dry wall with gashes through the dry wall next to bed A. Observations in room #208 on 07/08/16 at 4:01 PM revealed 6 holes punched into the dry wall with gashes through the dry wall next to bed A. During an interview and tour on 07/08/16 at 3:38 PM with an Account Manager who was responsible for housekeeping and environmental services he confirmed the stains in the sinks in the bathrooms of #410 and #411 were rust stains. He stated they had used rust away and lime away products and had been able to remove the rust stains from toilets but they had been unable to get the rust stains out of the sinks and it had been an ongoing problem. During an interview and tour on 07/08/16 at 3:52 PM with the Maintenance Director he explained the facility used a work order system and staff could access it at any time when they saw something that needed repair. He stated he also made rounds throughout the day and it was common for staff to stop him in the hallways to report things that needed to be fixed. He further stated staff were trained in orientation to fill out	F 253	3. Measures put into place to ensure that the alleged deficient practice does not reoccur include: The Director of Nursing/ Maintenance Director conducted an in-service/re-education for all staff on 07/28/16 regarding observation of cleanliness, walls, sinks for staining, any and all repair needs and appropriate process for reporting needed repairs. Members of the Interdisciplinary team will observe and inspect 10 resident rooms/ bathrooms per week for 4 weeks and then 10 random rooms every other week for 2 months to include observation of walls, condition of furnishings to include sinks. Any areas identified will be corrected. 4. The Administrator, and Maintenance Director will review data obtained during facility audits and rounds; Analyze the data and report patterns/trends to the QAPI committee every month x 3 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions based on identified trends/outcome to ensure continued compliance.	

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F 253	Continued From page 13 work orders so that repairs could be made. He acknowledged the dark brown stains in the sinks in the bathrooms of room #410 and #411 were rust and stated the sinks needed to be replaced. He stated he was unaware of the holes in the dry wall in room #208 next to bed A and stated the damage was caused by a bariatric bed that had been in the room in the past and used by a former resident. He further stated staff had not filled out a work order or reported the holes or scrapes in the dry wall to him but it needed to be repaired. During an interview on 07/08/16 at 4:13 PM the Administrator stated it was her expectation for staff to complete work orders for maintenance staff to do repairs. She stated it was also her expectation for housekeeping staff to report concerns to maintenance and repairs should be made.	F 253		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who	F 278		8/5/16

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F 278	Continued From page 14 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 observations, resident and staff interviews and record review the facility failed to conduct a vision assessment to accurately reflect a resident's visual abilities on the Minimum Data Set (MDS) for 1 of 1 sampled resident with a visual impairment (Resident #168). The findings included: Resident #168 was admitted to the facility on 06/23/16 with diagnoses that included macular degeneration, glaucoma and others. A documented titled "Nursing Admission Intake Form" dated 06/23/16 completed by Nurse #2 specified the resident's vision was "adequate" and the resident was diagnosed with macular degeneration. An activity assessment dated 06/29/16 completed by the Activity Director specified reading materials were not important at all to the resident because of "poor eyesight." The admission Minimum Data Set (MDS) dated 06/30/16 specified the resident's vision was adequate, her cognition was intact and she required extensive assistance with activities of	F 278	F278 SS=D Alleged deficient practice In Assessment Accuracy/ Coordination/Certified. 1.Resident #168 discharged from the facility on 07/08/2016. 2.All residents have the potential to be affected by the same alleged deficient practice; therefore, the Director of Nursing re-educated the Resident Care Management Director and the MDS Coordinator on RAI manual guidelines regarding completion and accuracy of assessments. The Director of Nursing and Resident Care Management Director will validate accuracy of MDS□ submitted on 07/10/2016 and modify any changes needed according to findings by 08/05/2016. Resident Care Management Director and MDS Coordinator have reviewed assessments of all residents	

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F 278	Continued From page 15 daily living and her active diagnoses included macular degeneration. This assessment was transmitted to the State. The vision Care Area Assessment (CAA) read in part, "She has a diagnosis of macular degeneration with no vision impairments noted with her glasses." On 07/05/16 at 3:50 PM Resident #168 was interviewed in her room. She was asked about the cleanliness of her room and stated, "I assume it's clean because I can't see very well. I am blind in one eye and don't see well out of my other eye." During the interview the resident wore glasses and was seated in her wheelchair positioned beside the bed. Resident #168's call bell was a gray handle attached to a gray cord attached to the wall. The cord was noted to be behind the resident and the call bell was laying in the bed. Resident #168 was asked if she could reach her call bell and she turned and asked, "Where is it?" Resident #168 stated that she had difficulty seeing her call bell because the bell was a similar color to the sheets on her bed making it difficult for her to find. She explained that she often relied on her roommate to call for assistance because she was not always able to see her call bell to call for assistance. She said she was fearful because her roommate was being discharged soon and worried what she would do for help without her roommate. Resident #168 added that with her visual impairment she would be able to see the bell better if it was red providing a visual contrast. Resident #168 went on to explain that her eyesight varied depending on contrast, lighting, shapes and sizes. She stated that no one in the facility had asked her about her eyesight or offered to make accommodations for her. On 07/07/16 at 8:55 AM the MDS Coordinator was interviewed and explained that she worked in	F 278	with vision challenges in the last 30 days to ensure coding accuracy. 3. Measures put into place to ensure that the alleged deficient practice does not reoccur Include: The Director of Nursing has conducted In-service/re-education for the Resident Care Management Director, MDS Coordinator, and nursing staff on 07/28/2016 regarding how to perform proper assessment, MDS accuracy,and proper coding as described in the RAI Manual. Resident Care Management Director and MDS Coordinator have reviewed all vision assessments completed in the last 30 days to ensure coding accuracy. The Resident Care Management Director will audit 10 vision assessments per month for 3 months to ensure accurate coding. 4. The Resident Care Management Director and Director of Nursing will review data obtained during assessment audits, analyze the data and report patterns/trends to the QAPI committee every month x 3 month. The QAPI committee will evaluate the effectiveness Of the above plan, and will add interventions based on identified trends/outcomes to ensure continued compliance.	

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F 278	Continued From page 16 another facility but had been asked to help complete MDS assessments. She stated that when completing an assessment she researched the chart, relied on nursing documentation and information from residents and families to accurately assess a resident. The MDS Coordinator stated that in the case of Resident #168 she completed her MDS assessment dated 06/30/16 including vision. She added that she spoke with Resident #168, observed she was wearing glasses but did not conduct a vision assessment but rather relied on nursing documentation to determine the resident's visual abilities. On 07/07/16 at 9:05 AM observations of Resident #168 being served breakfast in her room were made. The staff member placed the tray down, removed the dome lid, asked the resident if she needed anything and Resident #168 replied, "yes, I need you to tell me what it is I am eating I can't see the food to identify what's on my tray." The staff member oriented the resident to her breakfast tray and where each item was located. On 07/08/16 at 9:15 AM the Activity Director was interviewed and stated he conducted his activity assessment on Resident #168 and she told him that she "didn't see good." On 07/08/16 at 10:00 AM the Director of Nursing (DON) was interviewed and explained that Resident #168 showed no signs of not being able to see, stating, and "She has read my name badge." The DON reported she believed the MDS was accurate because Resident #168 had demonstrated her vision to be adequate.	F 278		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility	F 282		8/5/16

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F 282	Continued From page 17 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 reviews, and staff interviews the facility failed to implement care plan interventions by not applying fall safety mats to bedside as ordered for 1 of 3 residents. (Resident #157) The findings included: Resident #157 was admitted to the facility on 05/05/16 with diagnoses that included cerebrovascular accident (CVA), hemiplegia, dysphagia, and difficulty walking. Review of the most recent admission minimum data set (MDS) dated 05/12/16 revealed that Resident #157 required extensive assistance of two staff members for bed mobility, transfers, and dressing. The MDS also revealed that Resident #157 had limited range of motion to one upper and lower extremity and had no falls since admission to the facility. Review of care plan dated 05/31/16 read in part: At risk for falls related to mental status, recent fall, balance problem/standing, utilized assistive device, and CVA. The goal of care plan was Resident #157 would be free of falls. Interventions of care plan included low bed with safety mats (06/06/16.) Review of physician order dated 06/06/16 read low bed with safety mat while in bed. Observation on 07/05/16 at 3:04 PM of Resident #157 in bed in low position. The safety mat was folded up in the corner of the room not in place beside the bed. Observation on 07/06/16at 11:43 AM of Resident	F 282	F 282 SS=D Alleged deficient practice in Services by Qualified Persons/Per Care Plan 1.On 07/08/16 the Director of Nursing provided counseling/re-education to staff members caring for resident #157 to include care plan interventions with expectation to follow interventions put into place at all times. The Director of Nursing performed random room checks to resident #157's room at various times to ensure care plan interventions were being followed. 2. All residents have the potential to be affected by the same alleged deficient practice; therefore, The Director of Nursing, Unit Manager,and Assistant Director of Nursing completed an audit on the current resident population at risk for falls to ensure care plan interventions in place are being followed by all staff audit to be completed by 08/05/2016. 3. Measures put into place to ensure that the alleged deficient practice does not reoccur Include: The Director of Nursing conducted an in-service/re-education for all staff regarding fall prevention/following care plan interventions to ensure safety of	

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F 282	Continued From page 18 #157 in bed in low position. The safety mat was folded up in the corner of the room not in place beside the bed. Observation on 07/07/16 at 4:00 PM of Resident #157 in bed in low position. The safety mat was folded up in the corner of room not in place beside the bed. Interview with the Director of Nursing (DON) on 07/08/16 at 12:54 PM revealed that when they lay Resident #157 down the staff was expected to put his bed in the low position and place the safety mat on the floor beside his bed. Interview with Nursing Assistant #2 (NA) on 07/08/16 at 1:08 PM revealed that she routinely took care of Resident #157, NA #2 stated that when Resident #157 was in bed the bed was supposed to be in the low position. NA #2 stated that she saw a safety mat in his room a couple of days but did not recall seeing it in his room yesterday so she assumed that they discontinued it. NA#2 stated that Resident #157 received a shower yesterday and when he laid down after that she did not put the safety mat to his bedside because she assumed that they had been stopped.	F 282	all residents. The DON/ADON, and/or Unit Manager will perform checks on 6 random residents at risk for falls per week for 4 weeks, then 6 random residents every other week for 2 months to ensure care plan interventions are being followed. Any incorrect findings will be immediately corrected to ensure resident safety and reported to the Director of Nursing. Further staff education, counseling, and or disciplinary action with staff will be determined at that time by the Director of Nursing. 4.The Administrator and Director of Nursing will review data obtained during audits, concerns,and rounds; analyze the data and report patterns/trends to the QAPI committee every month for 3 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions based on identified trends/ outcomes to ensure continued compliance.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, and staff	F 312	F312 SS=D	8/5/16

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F 312	Continued From page 19 interviews the facility failed to return retracted foreskin to its correct anatomical position after perineal care for 2 of 3 male residents sampled for activities of daily living (Resident #116 and Resident #163.) The findings included: 1. Resident #116 was admitted to the facility on 04/20/15 with diagnoses that included benign prostatic hyperplasia (BPH) (enlarged prostrate) and neurogenic bladder. Review of the most recent quarterly minimum data set (MDS) dated 06/11/16 revealed that Resident #116 was cognitively intact and required limited assistance of one staff member with toileting. The MDS also revealed that Resident #116 had an indwelling urinary catheter. Review of "Report of Consultation" for Resident #116 dated 06/17/16 from Urologist read in part "had paraphimosis (retracted foreskin of uncircumcised male that could not be returned to its normal anatomic position) that I reduced-make sure foreskin is reduced with all cleaning and catheter changes." On 07/06/16 at 3:43 PM Resident #116 refused for surveyor to observe perineal care. Interview with Nursing Assistant (NA) #3 on 07/07/16 at 1:17 PM revealed that Resident #116 was fairly independent and she only had to assist him as needed. NA#3 stated that in the 2 weeks she had worked at the facility she had only had to assist Resident #116 to the bathroom one time because he was weak. NA #3 was not aware that Resident #116 had a indwelling urinary catheter and he was not on a check and change program and did not routinely provide perineal care to Resident #116. On 07/07/16 at 3:09 PM attempted to talk to Urologist but was unsuccessful he was out of the office for the week.	F 312	Alleged deficient practice in ADL Care Provided for Dependent Residents 1. On 07/08/2016 the Director of Nursing provided re-education to nursing Staff on peri-care specifically to include care for uncircumcised male residents. On 07/08/2016 the Director of Nursing checked resident #116, and resident #163 while staff was providing peri-care and ensured care was performed appropriately including retracted foreskin was returned to its correct anatomical position after perineal care was provided. 2. All residents have the potential to be affected by the same alleged deficient practice; therefore measures put into place to include: The Director of Nursing, Assistant Director of Nursing, and Unit Manager conducted an in-service/re-education for all nursing staff 07/28/16. The Director of Nursing, Unit Manager, and Assistant Director of Nursing will observe peri- care being provided to include uncircumcised male residents to ensure proper technique. To be completed by 08/04/2016. The Director of Nursing, Assistant Director of Nursing, and Unit Manager will randomly audit 5 caregivers per week x 4 weeks performing peri- care to include uncircumcised males, then 5 caregivers every other week for 2 months to ensure peri-care is provided appropriately.	

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F 312	Continued From page 20 Interview on 07/08/16 at 10:42 AM with the area staff development coordinator revealed that she provided the orientation training and the yearly training to staff in the facility. During orientation and training they went over each system of the body and during orientation there was a skills check off sheet that the new staff was required to complete. The area staff development coordinator stated they went over incontinent care in regards to infection control but did not specifically cover incontinent care of uncircumcised males. She further stated she would expect the NA's would come with that knowledge from their NA training course. The area staff development coordinator stated she would expect the NA's to pull the foreskin back and look for any signs of infection. Interview with the Director of Nursing (DON) on 07/0816 at 12:46 PM revealed that training on perineal care and infection control was done yearly and they had the NA's complete a check off of those items as well. The DON stated that perineal care of uncircumcised males was general knowledge and she would expect the NA's to have that knowledge when they were hired at the facility. The DON stated that she could schedule training on the proper cleaning of uncircumcised males so that all the staff was aware of the proper way to perform that care. 2. Resident #163 was admitted to the facility on 05/27/16 with diagnoses that included cancer, anemia, atrial fibrillation, hypertension, and Alzheimer's disease. Review of the most recent admission MDS dated 06/03/16 revealed that Resident #163 required extensive assist of 2 staff members for toileting and was frequently incontinent of bowel and bladder. Observation on 07/07/16 at 4:07 PM of NA #2	F 312	4. The Administrator and Director of Nursing will review data obtained from audits, analyze the data and report patterns/trends to the QAPI committee every month for 3 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions based on identified trends/ outcomes to ensure continued compliance.	

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providing perineal care to Resident #163 revealed that after retracting the foreskin of the penis NA #2 thoroughly washed and dried the penis, after drying the penis NA#2 did not pull the foreskin back over the penis to its correct anatomical location. NA#2 explained that she was going to leave the brief off Resident #163 at that time to allow his bottom to get some fresh air and proceeded to cover Resident #163 up with a sheet and confirmed that she was done with providing perineal care to Resident #163.
Interview on 07/08/16 at 10:42 AM with the area staff development coordinator revealed that she provided the orientation training and the yearly training to staff in the facility. During orientation and training they went over each system of the body and during orientation there was a skills check off sheet that the new staff was required to complete. The area staff development coordinator stated they went over incontinent care in regards to infection control but did not specifically cover incontinent care of uncircumcised males. She further stated she would expect the NA's would come with that knowledge from their NA training course. The area staff development coordinator stated she would expect the NA's to pull the foreskin back and look for any signs of infection.
Interview with the Director of Nursing (DON) on 07/0816 at 12:46 PM revealed that training on perineal care and infection control was done yearly and they had the NA's complete a check off of those items as well. The DON stated that perineal care of uncircumcised males was general knowledge and she would expect the NA's to have that knowledge when they were hired at the facility. The DON stated that she could schedule training on the proper cleaning of uncircumcised males so that all the staff was

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F 312	Continued From page 22 aware of the proper way to perform that care. Interview on 07/08/16 at 1:13 PM with NA#2 revealed that she did not recall being trained on cleaning uncircumcised males. NA#2 stated that she knows to pull the foreskin back and clean the tip of the penis and to dry it but "never really thought about pulling the foreskin" back over the penis to its correct anatomical position. NA#2 stated that the manner in which she provided perineal care to Resident # 163 was the "normal" way she cleaned all uncircumcised male residents.	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, staff and physician interviews and record review the facility failed to obtain a physician's order for a resident that readmitted to the facility with an indwelling urinary catheter for 1 of 1 sampled resident (Resident #167). The findings included: Resident #167 was admitted to the facility on 05/18/16. The Minimum Data Set (MDS) dated	F 315	F315 SS=D Alleged deficient practice In No Catheter, Prevent UTI, Restore Bladder 1. On 07/07/16 Resident #167, the attending Physician assessed resident and gave an order to include D/C removal of Catheter. On 07/07/16 the Nurse	8/5/16

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F 315	Continued From page 23 05/25/16 specified her cognition was severely impaired and always incontinent of bladder. The Care Area Assessment (CAA) dated 06/07/16 for incontinence specified Resident #167 was always incontinent of bladder and had an ileostomy for bowel. Review of Resident #167's medical record revealed she was hospitalized for altered mental status on 06/12/16 and re-admitted to the facility on 07/04/16. The hospital discharge summary with physician's orders did not specify Resident #167 was to have an indwelling urinary catheter. A document titled "Nursing Admission Intake Form" dated 07/04/16 completed by Nurse #3 specified Resident #167 had a urinary catheter. The nurse documented, "16FR (French) F/C (Foley catheter) to straight drain." On 07/07/16 at 9:20 AM observations of Resident #167 were made with the Director of Nursing (DON). The DON observed and reported that Resident #167 had a urinary catheter. The DON also reviewed Resident #167's medical record and confirmed there was not a physician's order for the urinary catheter. The DON reported that the admitting nurse would be responsible for clarifying orders, including an order to continue or discontinue the urinary catheter for Resident #167. On 07/07/16 at 9:24 AM the physician reviewed Resident #167's medical record and reported that he was not aware of the justification for the urinary catheter and that he did not see an order for the catheter; stating, "The hospital did not say to leave it in." On 7/07/16 the physician wrote an order to discontinue the urinary catheter. On 07/08/16 at 3:34 PM Nurse #3 was interviewed on the telephone and reported that	F 315	removed catheter for resident #167. 2. All residents have the potential to be affected by the same alleged deficient practice; therefore, The Director of Nursing, Unit Manager, and Assistant Director of Nursing will complete a 100% audit to ensure that all residents with a Catheter have an order and appropriate diagnosis by 08/04/2016. 3. Measures put into place ensure that the alleged deficient practice does not reoccur include: The Director of Nursing conducted an In-service/ re-education for all licensed Nursing staff on 07/28/2016 which included All residents with a catheter must have a physicians order with an appropriate diagnosis. The DON/ ADON/ UM will audit New admission residents/charts for catheters/orders/approved diagnosis of catheter upon admission weekly x 4weeks, then upon admission every other week for 2 months to ensure continued compliance. 4. The Administrator and Director of Nursing will review data obtained from audits, analyze the data and report patterns/trends to the QAPI committee every month for 3 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions based on identified trends/ outcomes to ensure continued compliance.	

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F 315	Continued From page 24 she admitted Resident #167 on 07/04/16. Nurse #3 stated she noted that Resident #3 had an indwelling urinary catheter but didn't realize there was not an order. She added that she did not clarify the urinary catheter with the physician but left notification for the physician to see the resident on the next visit.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to provide adequate supervision to prevent a resident from falling during independent transfers from bed to wheelchair for 1 of 2 residents. Resident # 26 had no sustained injuries from his falls. The findings included: Resident #26 was admitted to the facility on 02/8/13 with diagnoses that included Dementia, chronic pain syndrome, Alzheimer's disease, Diabetes, Hypertension, Chronic Obstructive Pulmonary Disease with previous episodes of bronchitis and pneumonia. The Minimum Data Set (MDS) annual assessment was completed 11/29/15 was reviewed on 07/07/16. The MDS annual assessment dated 11/29/15 indicated that the resident was severely cognitively impaired.	F 323	F323 SS=D Alleged deficient practice in Free of Accident Hazards/ Supervision/ Devices 1.On 07/08/2016 The Director of Nursing updated resident #26's care plan with an intervention to ensure bed is in a low position. The Director of Nursing then in-serviced staff providing care for resident of the added intervention. 2. All residents have the potential to be affected by the same alleged deficient practice;therefore, The Director of Nursing, Unit Manager, and Assistant Director of Nursing completed an audit	8/5/16

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F 323	Continued From page 25 The MDS also indicated the resident was incontinent of bowel and bladder functions. On 07/06/16 at 12:00 PM the resident observed sitting on side of bed while he ate his lunch. The resident sat with his legs hanging over side of the bed and his feet did not touch the floor. The bed was not in a low position. On 07/07/16 at 8:59 AM resident observed to be seated on side of bed while he ate his breakfast. The resident had his legs over the side of the bed and his feet did not touch the floor. The bed was not in a low position. A record review conducted on 7/7/16 revealed that a care plan to prevent falls was activated 11/25/15. The care plan had been reviewed by staff quarterly. The Care plan stated that the resident's fall risk was related to his mental status, history of previous falls, arthritis, and prescribed narcotic and psychotropic medications. The approaches to prevent falls included on the care plan were as follows: Encourage resident to ask for help; Ensure that resident has proper footwear as indicated and accepted; Place call light within reach; Observe for potential patterns of falls to identify possible causes; Offer/Assist to the toilet frequently and as accepted; Place frequently used items within reach; and Observe for potential medication related causes. The MDS assessment completed on 05/10/16 documented the resident had declined in ability to perform own Activities of Daily Living. There were declines documented in the resident's performance of personal grooming, bathing, toileting, and ambulation. In May the resident had changed from needing one person to assist with toileting and dressing to requiring two persons to assist in those activities. On 05/01/16 the resident had a fall when resident	F 323	on the current resident population at risk for falls to ensure care plan interventions in place are being followed by all staff on 07/29/2016. 3. Measures put into place to ensure that the alleged deficient practice does not reoccur Include: The Director of Nursing conducted an in-service/re-education for all nursing staff regarding fall prevention/following care plan interventions to ensure safety of all residents. Members of the interdisciplinary team will perform checks on 6 random residents per week for 4 weeks and then 6 random residents every other week for 2 months to ensure care plan interventions are being followed. If any findings indicate interventions are not being followed the finding will be corrected to ensure resident safety and reported to the Director of Nursing immediately so that re-education, counseling, and or/disciplinary action occur if needed. 4.The Administrator and Director of Nursing will review data obtained during audits, concerns,and rounds; analyze the data and report patterns/trends to the QAPI committee every month for 3 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions based on identified trends/ outcomes to ensure continued compliance.	

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F 323	Continued From page 26	F 323		

attempted to transfer by himself to bed from wheelchair. The record stated that resident had been observed sitting on floor in front of wheel chair. The resident reported that he tried to get in bed and slid down to the floor.
Another fall occurred on 05/19/16. The record of the fall stated resident had slid to the floor after he transferred himself to bed from wheel chair.
The resident had another fall on 06/30/16. The record stated that the resident was observed lying on bottom beside the bed. The report stated that the resident had attempted unassisted transfer from bed to the wheel chair. A staff member encouraged the resident to call staff for assistance when it was needed.
A staff interview was conducted on 07/06/16 with Nurse # 1 who stated Resident # 26 had sustained 2 or more falls within past 30 days. The Nurse stated that the resident did get out of bed independently and the resident did fall because he tried to transfer without calling for assistance.
During interview conducted on 07/07/16 at 11:10 AM with Nursing Assistant (NA) # 3 stated that she did not know the resident very well because she did not usually work on that unit. The NA stated that she had gotten her assignment for care of resident from the Kardex. She also said that the resident required assistance of one person to perform personal care, bathing, toileting, and transfers. She stated that the resident did assist during care after verbal cues were given. The resident performed limited activities during care.
On 07/08/16 at 11:38 AM a staff interview was conducted with Nurse #4. The Nurse stated that the resident's bed was usually kept in the low position. It was stated by the Nurse that the resident had a history of frequently attempting to

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F 323	Continued From page 27 get himself to the bathroom without calling for assistance by staff. Nurse #4 also stated that she did not know of any update to the resident's care plan after the 06/30/16 fall but that she would ask about the use of fall mat beside resident's bed. On 07/08/16 at 11:44 AM an interview was conducted with the Director of Nursing to ask about updates made to the resident's care plan. The DON stated that fall alarms had been placed on the resident's bed and in wheel chair after the two falls in May 2016. A referral to physical therapy evaluation was made. She further stated that the staff continued to remind the resident to call for assistance before attempting to transfer himself.	F 323		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to serve pureed food in an attractive manner. The findings included: On 07/06/16 at 9:05 AM the pureed breakfast meal was observed. The plates consisted of runny pureed oatmeal light brown in color, a runny light brown pureed meat and a runny white pureed food item, unidentified. The residents	F 364	F364 SS=E Alleged Deficient Practice In Nutritive Value/ Appear, Palatable/ prefer temp 1. The Dietary Manager on 07/08/16 in-serviced/re-educated dietary staff on puree consistency and training on puree diet preparation. This training included a description of puree texture to include; holds its shape on a plate when scooped.	8/5/16

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F 364	Continued From page 28 eating the pureed food were not able to be interviewed due to cognitive impairment. There was no garnish to the plate nor was the food presented in an attractive manner. On 07/06/16 at 12:21 PM the pureed lunch meal was observed. The pureed food was runny the three items served on the tray ran together to form the shape of the plate. The food items were light red-ish brown, a light brown item and a lighter brown item. The plate had no garnish nor was it served in an attractive manner. On 07/08/16 at 12:15 PM the lunch was observed with the Dietary Manager (DM) present. The pureed food items were green, brown and beige. The pureed food was runny and when plated the items ran together forming the shape of the plate. The DM was interviewed and reported that it was difficult to make pureed food look attractive. She did not indicate if she expected staff to try to make the pureed food look attractive for residents. The dietary manager attempted to thicken the pureed food to prevent the items from running together on the plate but continued to serve the pureed food without garnish.	F 364	2.The Dietary Manager will complete an audit of all residents plates receiving puree for appropriate texture to include presentation in an attractive manner by 08/05/2016. 3. Measures put into place to ensure that the alleged deficient practice does not reoccur include: The Dietary Manager conducted an in-service/re-education on puree consistency including a description of puree texture to all of the dietary staff on 07/08/16 & 07/21/16. The Dietary Manager will audit 6 random resident plates weekly x 4 weeks, then 6 random plates every other week x 2 months to ensure continued compliance. 4.The Administrator and Director of Nursing, and Dietary Manager will review data obtained during audits, concerns, and rounds; analyze the data and report patterns/trends to the QAPI committee every month for 3 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions based on identified trends/ outcomes to ensure continued compliance.	
F 371 SS=D	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	F 371		8/5/16

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F 371	Continued From page 29 (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 prevent the walk-in cooler and walk-in freezer floors from developing rust. The findings included: On 07/05/16 at 9:51 AM and initial tour of the facility's kitchen was made with the Dietary Manager (DM). During the tour, observations were made of the walk-in cooler floor that revealed spots of standing water on the floor. The floor of the walk-in cooler was dark brown almost black in appearance and closer inspection revealed rust had formed covering the majority of the floor. In the center of the floor a metal sheet had been placed measuring 2 feet by 2 feet to cover the rust but the extent of the rust exceeded the metal sheet. Observations were also made of the walk-in freezer that revealed standing water outside the unit. The DM offered no explanation for the standing water. Inside the walk-in freezer the floor had rust in the center extending to the back of the unit. The DM stated the rust had been in both units for a while and stated the rust was not able to be removed.	F 371	F371 SS=D Food Procure,Store/Prepare/Serve–Sanitary 1.On 07/08/16 The Maintenance Director ordered new flooring for the walk-in cooler and walk-in freezer. The flooring is scheduled to be replaced by 08/05/2016. 2. The Dietary Manager, and Maintenance Director will inspect walk- in cooler and walk in freezer for continued compliance once per week x 4 weeks, then once every other week x 2 months. 3. Measures put into place to ensure that the alleged deficient practice does not reoccur include: Replacement of the walk in cooler and walk in freezer by 08/05/2016,and weekly inspections by the Dietary Manager and Maintenance director as specified above. 4.The Administrator, Maintenance Director,and Dietary Manager will review data obtained during audits, concerns, and rounds; analyze the data and report patterns/trends to the QAPI committee	

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F 371	Continued From page 30	F 371	every month for 3 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions based on identified trends/ outcomes to ensure continued compliance.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 431		8/5/16

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F 431	Continued From page 31 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to secure a medication cart when left unattended for 1 of 1 observed medication cart. The findings included: On 07/08/16 at 9:30 AM a medication cart was noted to be at the nurses' station unattended and unlocked. During the observation there were no staff present but visitors and residents were. The cart remained unattended and unlocked. On 07/08/16 at 9:33 AM the Unit Manager approached the nurses' station and observed the unlocked medication cart. The Unit Manager was interviewed and reported the nurse assigned to the medication cart was assisting a resident but should not have left the cart unlocked. The Unit Manager locked the medication cart. On 07/08/16 at 9:38 AM Nurse #1 returned to the nurses' station and was interviewed, stating he was not aware the cart was unlocked. The Nurse added he had been having trouble getting the bottom drawer to close completely and suspected the drawer was causing the cart to not lock.	F 431	F431 SS=D Alleged deficient practice in Drug records, label/store drugs & Biological 1. On 07/08/2016 the Unit Manager locked the med cart. On 07/08/16 the Maintenance Director checked medication cart and removed a bag that had become jammed in the drawer mechanism preventing the cart from locking easily. The Director of Nursing provided counseling/ re-education to the Nurse to ensure medication cart was locked/ secure before leaving the area. 2. The Director of Nursing, and Unit Manager completed a 100% audit on 07/08/2016 of all medication carts in the facility to ensure all carts were secure and locked properly. 3. Measures put into place to ensure that the alleged deficient practice does not reoccur include: The Director of Nursing conducted an in-service/ re-education to all nursing staff on 07/28/2016 regarding all medication carts are to be locked before walking away. The Director of Nursing, Assistant Director of Nursing, and/or Unit Manager will audit medication carts for	

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F 431	Continued From page 32	F 431	compliance with being locked 3x per week for 4 weeks, then 3x every other week x 2 months to ensure continued compliance. 4.The Administrator, and Director of Nursing will review data obtained during audits, concerns,and rounds; analyze the data and report patterns/ trends to the QAPI committee every month for 3 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions based on identified trends/ outcomes to ensure continued compliance.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review the facility failed accurately assess and document a resident's	F 514	F514 SS=D Alleged deficient practice in Res Records- Complete/ Accurate/	8/5/16

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(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 514	Continued From page 33 vision for 1 of 1 sampled resident with a visual impairment (Resident #168). The findings included: 1. Resident #168 was admitted to the facility on 06/23/16 with diagnoses that included macular degeneration, glaucoma and others. A documented titled "Nursing Admission Intake Form" dated 06/23/16 completed by Nurse #2 specified the resident's vision was "adequate" and the resident was diagnosed with macular degeneration. An activity assessment dated 06/29/16 completed by the Activity Director specified reading materials were not important at all to the resident because of "poor eyesight." The admission Minimum Data Set (MDS) dated 06/30/16 specified the resident's cognition was intact and her active diagnoses included macular degeneration. On 07/05/16 at 3:50 PM Resident #168 was interviewed in her room. She was asked about the cleanliness of her room and stated, "I assume it's clean because I can't see very well. I am blind in one eye and don't see well out of my other eye." During the interview the resident wore glasses and was seated in her wheelchair positioned beside the bed. Resident #168's call bell was a gray handle attached to a gray cord attached to the wall. The cord was noted to be behind the resident and the call bell was laying in the bed. Resident #168 was asked if she could reach her call bell and she turned and asked, "Where is it?" Resident #168 stated that she had difficulty seeing her call bell because the bell was a similar color to the sheets on her bed making it difficult for her to find. She explained that she often relied on her roommate to call for assistance because she was not always able to see her call bell to call for assistance. She said	F 514	Accessible 1. The Director of Nursing provided education to the nursing staff regarding completion of assessments accurately. Resident #168 discharged from the facility on 07/08/2016. Multiple vision assesments were completed prior to resident's discharge. The Director of Nursing re-educated the MDS Coordinator on RAI manual guidelines regarding completion and accuracy of assessments. 2. All residents have the potential to be affected by the same alleged deficient practice; therefore, The DON/ ADON/ UM will audit all new admission assessments for the current population x the last 30 days to ensure accuracy to be completed by 08/05/2016. 3. Measures put into place to ensure that the alleged deficient practice does not reoccur include: The Director of Nursing conducted an in-service/ re-education to all nursing staff on 07/28/2016 regarding completion of assessment accurately The Director of Nursing, Assistant Director of Nursing, and Unit Manager will audit new Admission assessments weekly x 4 weeks, then every other week x 2 months to ensure continued compliance. 4.The Administrator, Director of Nursing and Resident Care Management Director	

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	345080	A. BUILDING _____ B. WING _____	C 07/08/2016

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F 514	Continued From page 34 she was fearful because her roommate was being discharged soon and worried what she would do for help without her roommate. Resident #168 added that with her visual impairment she would be able to see the bell better if it was red providing a visual contrast. Resident #168 went on to explain that her eyesight varied depending on contrast, lighting, shapes and sizes. She stated that no one in the facility had asked her about her eyesight or offered to make accommodations for her. On 07/07/16 at 3:20 PM Nurse #2 was interviewed and recalled being the admitting nurse for Resident #168 adding it had been a very busy night. The nurse explained that he "asked straight up" how a resident's vision was depending on the resident's cognition and then would stand 20 feet away from the resident and hold up fingers to assess the visual ability. He added that Resident #168's cognition was "okay" but he could not recall if he asked the resident about her vision nor could he recall assessing her ability to see, stating it was possible he made a mistake. On 07/07/16 at 9:05 AM observations of Resident #168 being served breakfast in her room were made. The staff member placed the tray down, removed the dome lid, asked the resident if she needed anything and Resident #168 replied, "yes, I need you to tell me what it is I am eating I can't see the food to identify what's on my tray." The staff member oriented the resident to her breakfast tray and where each item was located. On 07/08/16 at 9:15 AM the Activity Director was interviewed and stated he conducted his activity assessment on Resident #168 and she told him that she didn't "see good." On 07/08/16 at 10:00 AM the Director of Nursing (DON) was interviewed and explained that	F 514	will review data obtained during audits, concerns,and rounds; analyze the data and report patterns/ trends to the QAPI committee every month for 3 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions based on identified trends/ outcomes to ensure continued compliance.	

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F 514	Continued From page 35 Resident #168 showed no signs of not being able to see, stating, "She has read my name badge." She added Resident #168 tried to gain sympathy from staff at times. The DON reported that she believed the medical record was accurate because Resident #168 had demonstrated her vision to be adequate.	F 514		
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:	F 520		8/5/16

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F 520	Continued From page 36 The facilities Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in July of 2015. This was for 3 recited deficiencies which were originally cited in June of 2015 on a Recertification survey and subsequently recited in July of 2016 on the current recertification survey. The deficiencies were in the areas of housekeeping and maintenance, resident assessment, and Activities of Daily Living (ADL.) The findings included: This tag is cross referred to: 1a. F 253 House Keeping and Maintenance: Based on observations and staff interviews the facility failed to repair stained sinks in 2 resident bathrooms on 1 of 4 resident hallways (Room #410 and #41) and failed to repair damaged walls in 2 resident rooms (Room #201 and # 208) on 1 of 4 resident hallways. During the recertification survey on June 04, 2015 the facility was cited for failure to keep personal care equipment stored to prevent contamination, maintain walls in good condition, keep bathrooms in good and clean condition, and maintain furnishing in good condition. b. F 278 Assessment Accuracy: Based on observations, resident and staff interviews and record review the facility failed to conduct a vision assessment to accurately reflect a resident's visual abilities on the Minimum Data Set (MDS) for 1 of 1 sampled resident with a visual impairment (Resident #168). During the recertification survey on June 04, 2015 the facility was cited for failure to accurately complete the Minimum Data Set (comprehensive assessment) for 2 of 19 residents whose assessments were reviewed. c. F 312 ADL care provided for dependent	F 520	F520 SS=D Alleged deficient practice QAA Committee- Members/ Meet Quarterly/ Plans 1. The District Director of Clinical Services will conduct re-education for the Administrator on the facility's Quality Assurance and Performance Improvement Program including meeting schedules, identification of trends or patterns, submission of data, and initiation of quality improvement plans related to identified areas of opportunity by 08/05/2016. All members of the Quality Assurance and Performance Improvement Committee submit data related to each department and participate in the identification of areas in need of improvement. The Administrator and the Quality Assurance Committee will be retrained on the Quality Assurance & Performance Improvement Program. This training will be completed by the District Director of Clinical Services. The Quality Assurance committee consists of: • Administrator • Director of Nursing • Dietary Manager • Rehabilitation Manager • Maintenance or Environmental Representative • Activities Director • Social Services Director	

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F 520	Continued From page 37 residents: Based on observation, record reviews, and staff interviews the facility failed to provide proper perineal care to 2 of 3 male residents sampled for activities of daily living (Resident #116 and Resident #163.) During the recertification survey on June 04, 2015 the facility was cited for failure to provide nail care a dependent resident for 1 of 3 residents reviewed for ADLs (Resident #81.) An interview with the Administrator on 07/08/16 at 6:09 PM revealed that after the June 04, 2015 she changed housekeeping mangers. In addition to a new house keeping manager his entire department was new. In their daily stand up meeting the housekeeping manager would tell her what rooms were being deep cleaned and the following day she would go and check those rooms to ensure they were up to her standard. The administrator stated that they have been working diligently throughout the building to make the necessary repairs, the 500 hall just went through a complete renovation and 200 hall shower room was in the process of being remodeled. The Administrator also stated that all of the privacy curtains had been replaced and they have painted the entire building and the front lobby was getting new furniture. The Administrator pointed out that in the next 12 weeks they would be remodeling the central nurse's station. The Administrator stated that the Area staff development coordinator would be going over correct perineal care in orientation and the DON would do the onsite training and that they had already in- serviced first and second shift on proper perineal care of male residents. The Administrator stated she felt like the implemented procedures would correct the problems and that survey preparation was such an important part of running the building because	F 520	• Business Office Director • Resident Care Management Director • Medical Director 2. The Administrator and the Director of Nursing will present the results of all audits to the Quality Assurance & Performance Improvement committee weekly for four (4) weeks and then monthly thereafter. 3. The next Quality Assurance & Performance Improvement meeting will be conducted weekly for four weeks, then monthly with oversight by District Director of Clinical Services for three months 4. Measures to ensure that corrections are achieved & sustained include: The results of these audits and observations will be presented by the Administrator and Director of Nursing weekly for 4 weeks, then monthly for 3 months at facility Quality Assurance Performance Improvement Committee Meeting. The committee will amend the plan based on identified audit trends. These amendments will be implemented immediately following the meeting and monitored once weekly x 4 weeks then once monthly x 3 months. 5. Date of compliance: August 05 2016	

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F 520	Continued From page 38 that ws where they identified areas that need attention.	F 520		