STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345162	A. BUILDING _____ B. WING _____	C 10/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GASTONIA CARE AND REHABILITATION	416 N HIGHLAND STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility records, and resident and staff interviews, the facility failed to assess a resident regarding the time of day and number of showers preferred a week for 1 of 2 residents reviewed for choices (Resident #4). The findings included: Resident #4 was admitted to the facility on 06/04/15 with diagnosis including diabetes mellitus, hyperglycemia, dysphagia with gastrostomy tube, and cataracts. Review of the quarterly Minimum Data Set (MDS) dated 08/05/16 revealed Resident #4 was cognitively intact and able to make his needs known. The quarterly MDS noted he required supervision with transfer, walking in his room and the corridor, and extensive assistance of one person with bathing. Review of the facility's second floor shower schedule revealed Resident #4 was scheduled for showers on Monday and Thursday during the 3:00 PM to 11:00 PM shift (2nd shift).	F 242	Preparation and/ or execution of this Plan of Correction does not constitute admission or agreement of by the provider of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and / or executed solely because it is required by the provisions of the Federal and State Law. 1. Resident #4 was interviewed by Nurse #1 and Director of Nursing in regards to his preferred shower days, time and frequency on October 10, 2016. Resident # 4 stated he prefers 3 showers a week in the morning Monday, Wednesday, and Friday. Resident□s shower preference was documented in the nurse□s notes, care planned and reflected on the Shower Preference Chart on the unit for communication. 2. On October 12, 2016 licensed staff, Staff Development Coordinator and Assistant Director of Nursing initiated	11/3/16

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

Electronically Signed | 10/29/2016

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F 242	Continued From page 1 During an interview on 10/03/16 at 3:54 PM Resident #4 stated he was told his showers were scheduled for Monday and Thursday evenings. Resident #4 further stated no one had ever asked him how many showers he wanted a week and noted his shower was in evening because he was on the "B" bed. The interview revealed Resident #4 preferred to shower in the morning and would like 3 or 4 showers a week. An interview with Nurse Aide (NA) #2 on 10/05/16 at 4:22 PM revealed residents received two showers a week based on their room number and bed assignment. NA #2 stated she checked the shower book after she gets her assignment to see which residents were scheduled for showers on her shift that day. NA #2 stated residents could get additional showers if they requested. During an interview on 10/06/16 at 10:03 AM Nurse #1 stated residents were scheduled for two showers a week based on their room and bed assignment. Nurse #1 further stated residents could get additional showers if they requested. An interview was conducted with the Director of Nursing (DON) on 10/06/16 at 11:26 AM. The DON stated residents were scheduled for two showers a week based on their room assignment and they would have to ask if they wanted more than two showers a week. The DON indicated residents were not assessed regarding their preference for the time of day they showered or the number of showers they received every week.	F 242	interviewing all residents and responsible parties for residents unable to be interviewed in regards to their shower preferences, this was completed on October 25, 2016. Shower preferences were documented in the nurse□s notes and care plan. Shower Preference Chart was initiated on every unit to reflect all resident□s choices of days, times and frequencies of showers. 3. The nursing staff will be inserviced regarding the resident has the right to choose individualized choice for shower preference for days, time and frequencies. This education will be completed by November 1, 2016 by the Staff Development Coordinator, Assistant Director of Nursing and/or Director of Nursing. ` 4. Ongoing audit by Staff Development Coordinator, Assistant Director of Nursing, Director of Nursing and Licensed Nurses to monitor the resident□s shower preferences provided to residents per resident□s choice as listed in the Shower Preference Chart on the Unit. Five residents will be interviewed daily for the next 2 weeks and 3 residents daily for the next 2 weeks. Monitoring will continue for the next three months by interviewing one resident three times per week to ensure compliance. All data will be summarized and presented at the facility QAPI meeting monthly by the DON. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to insure continued	

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F 242	Continued From page 2	F 242	compliance. The QAPI committee consists of the Administrator, DON, SDC, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services and Environmental services. Other members may be assigned as the need arise.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to keep a commode in clean and sanitary condition and label and store personal hygiene products and resident care equipment properly. In addition, the facility also failed to keep bathroom floors free of stains around the base of the commodes, keep ceilings free from stains, paint scratched doors and door frames, paint existing patched walls, patch and paint holes in doors and walls, and replace knobs on closet drawers on 4 of 4 halls. The findings included: 1. Observations of the shared bathroom in room 228 on 10/03/16 at 4:09 PM revealed several areas of dried brown matter on the surface of the inside and top of the toilet bowl. In addition, there were also several areas of dried brown matter on the underside of the elevated toilet seat.	F 253	. The shared bathroom in RM 228 toilet bowel, elevated toilet seat and RM 221 floor around the base of the commode was cleaned on 10/7/16 by house keeper. 2. Resident bathrooms were cleaned by housekeeping staff and verified by the Director of Plant Operation as of October 7. 3. All housekeeping and laundry staff have been in-serviced by Plant Operations Manager and Staff Development Coordinator (SDC) on cleaning and sanitizing bathrooms; dusting and sweeping floors following mopping per policy as of October 28th. The Plant Operations Manager has been re in-serviced by his the Signature	11/3/16

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F 253	Continued From page 3 Observations of the shared bathroom in room 228 on 10/04/16 at 8:41 AM revealed several areas of dried brown matter on the surface of the inside and top of the toilet bowl. In addition, there were also several areas of dried brown matter on the underside of the elevated toilet seat. Observations of the shared bathroom in room 228 on 10/05/16 at 8:45 AM revealed several areas of dried brown matter on the surface of the inside and top of the toilet bowl. In addition, there were also several areas of dried brown matter on the underside of the elevated toilet seat. Observations of the shared bathroom in room 228 on 10/05/16 at 1:03 PM revealed several areas of dried brown matter on the surface of the inside and top of the toilet bowl. In addition, there were also several areas of dried brown matter on the underside of the elevated toilet seat. During an interview on 10/05/16 at 2:37 PM Housekeeper #1 stated part of her daily assignment were the rooms on the two short halls on each floor, which included room 228. Housekeeper #1 confirmed she had finished cleaning room 228 and the bathroom earlier in the day. Housekeeper #1 further stated when she cleaned a bathroom she sprayed the bath tub, sink, and commode with disinfectant and used a brush to clean the inside of the bowl and wiped down all the surfaces of the toilet with a rag. If there was an elevated toilet she sprayed the top and underside with disinfectant and wiped it down with a rag. Housekeeper #1 was then accompanied to room 228 and observed the commode and elevated toilet seat and stated she would need to clean them again. Housekeeper #1 explained she could have missed cleaning the	F 253	Regional Plant Operations Manager on how to maintain the facility appearance and functionality as of October 28th. 4. The Monitoring Compliance with Infection Control Checklist will be used by Head of Maintenance or SDC to monitor compliance with Maintenance Services, Housekeeping Services, and Laundry Services. Staffs of these departments have been re-in serviced by the SDC and Plant Operation Manager on what is expected in-order to be compliant as of October 28th. Department Heads will continue to do daily room rounds to inspect their assigned rooms for cleanliness and need for possible repairs. The documentation of the room rounds will be passed to the Administrator in the morning standup meeting. Work orders will be added to the electronic TELS (a system for monitoring all areas of maintenance for the facility) system by the Administrator or designee. The Head of Maintenance and his Assistant will have access to TELS through facility computers and through new computer tablets (2) that access the mobile application that will help the Head of Maintenance and his Assistant to be more efficient in receiving work orders and signing off when work orders are completed. The new mobile devices were purchased and put in use on October 19th. The Administrator will continue to do daily rounds on the unit with the addition of inspecting 10% of the bathrooms at least weekly as of October 28th. The findings of	

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F 253	Continued From page 4 commode and elevated toilet seat because sometimes she got in a hurry. An interview was conducted with the Plant Operations Manager on 10/05/16 at 2:50 PM. The Plant Operations Manager stated he expected the housekeepers to clean the inside of the toilet bowl and spray and wipe down the entire outside of the commode all the way down to the floor every day. He also expected elevated toilet seats to be cleaned when the commode was cleaned. The Plant Operations Manager stated it was not acceptable for a resident to have a dirty commode and elevated toilet seat for 3 days. 2. a. Observations of the shared bathroom in room 217 on 10/03/16 at 3:33 PM revealed 2 uncovered and unlabeled toothbrushes in an unlabeled emesis basin on the back of the commode. In addition, there was a clear plastic bin on the back of the commode that contained an unlabeled tube of toothpaste. Observations of the shared bathroom in room 217 on 10/04/16 at 9:20 AM revealed 2 uncovered and unlabeled toothbrushes in an unlabeled emesis basin on the back of the commode. In addition, there was a clear plastic bin on the back of the commode that contained an unlabeled tube of toothpaste. The emesis basin had been place inside of the plastic bin at the time of this observation. Observations of the shared bathroom in room 217 on 10/05/16 at 9:54 AM revealed 2 uncovered and unlabeled toothbrushes in an unlabeled emesis basin on the back of the commode. In addition, there was a clear plastic bin on the back of the commode that contained	F 253	these inspections will be brought by the Administrator to QAPI meetings monthly for three months. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised to ensure continued compliance. The Quality Assurance Performance Improvement Committee consists of the Administrator, the Director of Nursing, Staff Development Coordinator, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services and Environmental Services. Personal items in the bathroom 1. Personal items including toothbrushes and toothpastes in the bathrooms for each resident in room 217 have been placed in a plastic caddie then placed in a clear enclosures/bags and labeled with the resident□s name by Nursing Staff as of October 28th. Personal items including toothbrushes and toothpastes in the bathrooms for each resident in room 215 have been placed in a plastic caddie then placed in a clear enclosures/bags and labeled with the resident□s name by Nursing Staff as of October 28th. Resident in room 215 had urine hats placed in a clear enclosures/bags and labeled with each resident□s name and stored off the floor by Nursing Staff as of October 19th. 2. All Residents with urine hats have had	

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F 253	Continued From page 5 an unlabeled tube of toothpaste. The emesis basin had been place inside of the plastic bin at the time of this observation. Observations of the shared bathroom in room 217 on 10/06/16 at 8:56 AM revealed 2 uncovered and unlabeled toothbrushes in an unlabeled emesis basin on the back of the commode. In addition, there was a clear plastic bin on the back of the commode that contained an unlabeled tube of toothpaste. The emesis basin had been place inside of the plastic bin at the time of this observation. During an interview on 10/06/16 at 10:06 AM the Director of Nursing (DON) stated she liked residents' personal hygiene products to be stored in their bedside tables but they could be stored in the bathroom if they were covered and labeled. The DON was accompanied to the shared bathroom in room 217 on 10/06/16 at 10:10 AM and stated the toothbrushes should be labeled and covered and the toothpaste should be labeled. 2. b. Observations of the shared bathroom in room 215 on 10/03/16 at 3:26 PM revealed an unlabeled and uncovered urine collection hat on the floor behind the commode. Observations of the shared bathroom in room 215 on 10/04/16 at 4:11 PM revealed an unlabeled and uncovered urine collection hat on the floor behind the commode. Observations of the shared bathroom in room 215 on 10/05/16 at 9:50 AM revealed an unlabeled and uncovered urine collection hat on the floor behind the commode.	F 253	their urine hats placed in a clear enclosures/bags and labeled with each resident□s name and stored off the floor as of October 19th. All personal items in the bathrooms of all resident in the facility have been stored in a plastic caddie and the caddie placed in clear enclosures/bags and labeled with the resident□s name as of October 19th. 3. All housekeeping staff has been in-serviced by the DON or SDC on placing personal items including toothbrushes in the bathroom in a plastic caddie, and the caddie placed in a labeled plastic bag as of October 28th. 4. Department Heads will continue to do morning room rounds to inspect their assigned rooms for resident□s bathroom items to be stored in a plastic caddie and the plastic caddie placed in clear enclosures/bags with the resident□s name on it when not in use by the resident. Any items not stored appropriately will be place in their appropriate labeled storage bag. If the resident□s storage bag is not available one will be created by the assigned Department Head or other designated staff member as of October 28th. The Administrator will continue to do daily rounds on the unit with the addition of inspecting 10% of the bathrooms at least weekly. This to include ensuring personal items is being stored appropriately as of October 28th. 1.	

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F 253	Continued From page 6 An interview with the DON on 10/06/16 at 4:00 PM revealed personal care equipment should be labeled and bagged and stored off the floor. The DON was accompanied to room 215 on 10/06/16 at 4:02 PM and stated the urine collection should not be on the floor and should be discarded. 3. a. Observations of room 210 on 10/03/16 at 12:08 PM revealed patched and unpainted areas around the light fixture over bed B, blue painters tape on the floor near the baseboards, and the wall behind bed A had a area approximately 3 feet wide that extended the entire length of the bed with the paint scratched off to the dry wall. Observations of the bathroom revealed the outside of the bathroom door had paint scratched off at the bottom and side of the door, three gouged scratches on the left entry wall which were approximately 12 inches long, dime sized holes in the wall near the paper towel dispenser that needed patching and painting, and the wall behind the mirror needed painting. In addition, the floor around the base of the commode was stained black. A subsequent observation of room 210 on 10/05/16 at 9:45 AM revealed no change in the appearance of the resident room or bathroom. The Administrator and Maintenance Director also observed these areas when taken on an environmental tour beginning on 10/06/16 at 4:38 PM. b. Observations of room 214 on 10/03/16 at 12:14 PM revealed dime sized holes in the wall next to the paper towel holder in the bathroom that needed patching and painting. Subsequent observations on 10/04/16 at 9:17 AM and 10/05/16 at 9:48 AM revealed the holes in the bathroom wall still needed painting and patching.	F 253	Personal items including urine hats in the bathrooms for each resident in room 217 have been placed in a plastic caddie which have then been placed in a clear enclosures/bags and labeled with the resident□s name as of October 28th. 2. All personal items in the bathrooms of all resident in the facility have been stored in a plastic caddie and the caddie placed in clear enclosures/bags and labeled with the resident□s name by Nursing or Housekeeping staff as of October 28th. 3. All housekeeping staff have been in-serviced by the Director of Nursing (DON) or SDC on placing personal items including urine hats in the bathroom in a plastic caddie, and the caddie placed in a labeled plastic bag as of October 28th. 4. Department Heads will continue to do daily room rounds to inspect their assigned rooms for resident□s bathroom items to be stored in a plastic caddie and the plastic caddie placed in clear enclosures/bags with the resident□s name on it when not in use by the resident. Any items not stored appropriately will be place in their appropriate labeled storage bag. If the resident□s storage bag is not available one will be created by the assigned Department Head or other designated staff member as of October 28th. The Administrator will continue to do daily rounds on the unit with the addition of inspecting 10% the bathrooms at least	

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F 253	Continued From page 7 The Administrator and Maintenance Director also observed these areas when taken on an environmental tour beginning on 10/06/16 at 4:38 PM. c. Observations of room 215 on 10/03/16 at 3:32 PM revealed dime sized holes in the wall next to the paper towel holder in the bathroom that needed patching and painting. There was also a missing knob on the closet drawer approximately 12 inches from the floor leaving an exposed metal screw which extended out approximately 1/2 of an inch. Subsequent observations on 10/04/16 at 9:35 AM and 10/05/16 at 9:50 AM revealed the holes in the bathroom wall still needed painting and patching and the knob was still missing from the closet drawer. The Administrator and Maintenance Director also observed these areas when taken on an environmental tour beginning on 10/06/16 at 4:38 PM. d. Observations of room 217 on 10/03/16 at 3:32 PM revealed the top layer of paint was scratched off in several places behind bed A, a quarter sized whole in the outside of the hollow bathroom door, the outside of the bathroom door had paint scratched of the bottom and side of the door, the left bathroom faucet was not functional, and the bathroom door frame had paint scratched and gouged off down to the metal on the entry side of the door. Subsequent observations of room 217 on 10/04/16 at 9:19 AM and 10/05/16 at 9:51 AM revealed no change in the appearance of the resident room or bathroom. The Administrator and Maintenance Director also observed these areas when taken on an environmental tour beginning on 10/06/16 at 4:38 PM.	F 253	weekly. This to include ensuring personal items is being stored appropriately as of October 28th. Paint and Patch 1. Room 201, 210, 214, 215, 217, 221, 231,232, 233, 234, 236 and 237 have had the area around the light fixture patched and painted around the light fixture and around the mirror, toilet paper holder and towel dispenser when needed by Signature Maintenance Staff as of October 28th . Room 210 and 204 has had the tape removed from the floor along the baseboards by the Head of Maintenance as of October 28th. Room 132 had white paint spots inside and outside the bathroom painted over with a paint that corresponds to the paint color of the rest of the room by Head of Maintenance as of October 28th. Room 132 had the wall paper removed and related wall painted to correspond to the rest of the room by the Head of Maintenance as of October 28th. Room 132, 231 and 128 will have the ceiling tiles repaired or replaced by Head of Maintenance as of October 28th. Room 201, 203, 204, 210, 217, 221, 229, 231 and 412 has had the bare places repainted by Signature Maintenance Staff as of October 28th. Room 210, 231, 232, and 229 have had the bathroom door gouges filled in by the Head of Maintenance as of October 28th. Room 210, 217, 234, 215 and 214 have had hole in wall corrected by the Head of Maintenance as of October 28th.	

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F 253	Continued From page 8 e. Observations of room 221 on 10/04/16 at 9:07 AM revealed the top layer of paint was scratched off a large area of the wall behind bed B, the outside of the bathroom door had paint scratched of the bottom and side of the door, one of the bathroom faucets was not functional, the bathroom door frame had paint scratched and gouged off down to the metal on the entry side of the door, dime sized holes in the wall next to the paper towel holder in the bathroom that needed patching and painting, and the floor around the base of the commode was stained black. A subsequent observation of room 221 on 10/05/16 at 9:13 AM revealed no change in the appearance of the resident room or bathroom. The Administrator and Maintenance Director also observed these areas when taken on an environmental tour beginning on 10/06/16 at 4:38 PM. f. Observations of room 229 on 10/04/16 at 8:38 AM revealed the wall behind the entry door had a patched area the size of a grapefruit that needed sanding and painting, a quarter sized whole in the outside of the hollow bathroom door, the outside of the bathroom door had paint scratched of the bottom and side of the door, the bathroom door frame had paint scratched and gouged off down to the metal on the entry side of the door, dime sized holes in the wall next to the paper towel holder in the bathroom that needed patching and painting, and the wall under the clock and next to the A bed had areas where the top layer of paint had been scratched off. There were also 2 missing knobs on the closet drawer approximately 12 inches from the floor leaving an exposed metal screw which extended out approximately 1/2 of an inch. A subsequent observation of room 229 on 10/05/16 at 8:47 AM	F 253	Room 210 has had the area behind the mirror painted by the Head of Maintenance as of October the 28th. Rooms 217 and 221 have had bathroom faucets repaired by Head of Housekeeping as of October the 28th. Room 229 has had the patch on the outside of the bathroom door sanded and painted and the frame painted by Signature Maintenance staff as of October the 28th. Room 128 and 108 had white paint spots inside the room painted over with a paint that corresponds to the paint color of the rest of the room by Signature Maintenance Staff as of October the 28th. Cabinet knobs in room 215, 230, 233, and 237 have been fixed or repaired by Head of Housekeeping as of October 28th. 2. All rooms have had the tape removed as the floor along the baseboards as of November 3rd.. All rooms will have their ceiling tiles inspected and repaired or replaced as needed as of November 3rd. All rooms have had painting tape removed, dry wall repaired, bathroom doors patched and gauges repaired as of November 3rd. All rooms have had door stops installed to prevent the bedroom door□s opening from damaging the bedroom walls as of November 3rd. 3. The Head of Maintenance was in-serviced by the Regional Director of Plant	

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F 253	Continued From page 9 revealed no change in the appearance of the resident room or bathroom. The Administrator and Maintenance Director also observed these areas when taken on an environmental tour beginning on 10/06/16 at 4:38 PM. g. Room 237, shared by 2 residents, was observed on 10/03/16 at 12:44 PM with patched unpainted areas around both light fixtures above each bed. This area remained unpainted along with an observation of 1 of 4 of the knobs from the closet drawers missing, which left the end of a flat screw extending out form the drawer when observations were made on 10/04/16 at 8:23 AM and on 10/04/16 at 3:32 PM. Additional observations on 10/04/16 at 9:47 AM and on 10/06/16 at 4:38 PM revealed the same unpainted walls, missing screws and painters tape left along the baseboard behind the bed. The Administrator and Maintenance Director also observed these areas when taken on an environmental tour beginning on 10/06/16 at 4:38 PM. h. Room 236, shared by 2 residents, was observed on 10/03/16 at 11:56 AM with patched and unpainted areas around both light fixtures above each bed and unpainted and holes in the bathroom around the mirror, toilet paper holder and towel dispenser. These areas remained the same during observations made on 10/04/16 at 8:26 AM, on 10/04/16 at 3:23 PM, on 10/05/16 at 9:40 AM , and on 10/06/16 at 10:54 AM. The Administrator and Maintenance Director also observed these areas when taken on an environmental tour beginning on 10/06/16 at 4:38 PM. i. Room 234, shared by 2 residents, was	F 253	Operations on October 28th on maintaining Center appearance. 4. Department Heads will continue to do daily room rounds to inspect their assigned rooms for cleanliness and need for possible repairs. The documentation of the room rounds will be passed to the Administrator in the morning standup meeting. Work Orders will be added to the electronic TELS system by the Administrator or his designee. The Head of Maintenance and his Assistant will have access to TELS through facility computers and through new computer tablets (2) that will help the Head of Maintenance and his Assistant to be more efficient in receiving work orders and signing off when work orders are completed. The new mobile devices were purchased and put in use on October 19th. The Administrator will continue to do daily rounds on the unit with the addition of inspecting 10% of the interior of room at least weekly, referring any found concerns to Maintenance through the TELS system. The Administrator will monitor work order completion through plant observation and through logging into the TELS system as of October 28th. The Administrator of Gastonia Care and Rehabilitation Center is currently actively recruiting additional Maintenance staff to aid current Plant Operations Manager in maintaining facilities appearance and functionality. This is ongoing. The Administrator recognizes that plant maintenance and housekeeping is an ongoing process. At this time no major	

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observed on 120/03/16 at 12:02 PM with unpainted areas on the wall at the end of the light fixture above bed A, 2 areas approximately one foot by one foot on the bedroom wall that was unpainted following the removal of a square item, and holes and unpainted areas around the toilet paper dispenser. These areas remained the same during observations made on 10/05/16 at 11:25 AM, on 10/06/16 at 10:53 AM and during with the Administrator and Maintenance Director beginning on 10/06/16 at 4:38 PM.

j. Room 233, shared by 2 residents, was observed on 10/04/16 at 8:58 AM with patched unpainted areas around the light fixtures above each bed and unpainted areas around the bathroom mirror, toilet paper holder and towel dispenser. In addition to these areas, 2 of 4 knobs on the closet drawers were observed missing. leaving a flat ended screw extending outward during observations made on 10/04/16 at 3:27 PM, on 10/05/16 at 9:53 AM, on 10/06/16 at 10:51 AM. The Administrator and Maintenance Director also observed these areas when taken on an environmental tour beginning on 10/06/16 at 4:38 PM.

k. Room 232, shared by 2 residents, was observed on 10/03/16 at 11:48 AM with patched unpainted areas around the light fixtures above both bed, missing dry wall along the corner of the wall by the bathroom leaving exposed metal, a hole in the hollow bathroom door and holes and unpainted areas around the toilet paper dispenser. These areas remained this way during observations made on 10/04/16 at 2:14 PM. These areas in addition to 2 of 4 missing knobs on the closet drawers with flat head screws extending outward were observed on 10/04/16 at

building structure changes are planned.

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9:50 AM, 10/06/16 at 10:48 AM. The Administrator and Maintenance Director also observed these areas when taken on an environmental tour beginning on 10/06/16 at 4:38 PM.

l. Room 231, shared by 2 residents, was observed on 10/03/16 at 11:41 AM with patched unpainted areas around both light fixtures above the beds, a patched unpainted area by the door across from bed a, a patched unpainted four foot high area on the corner of the wall near the bathroom. In addition, there was a hole in the hollow bathroom door and the bathroom walls were left unpainted with holes where the mirror, the toilet paper holder and towel dispenser had been replaced and the new fixtures did not cover the previous color paint or holes. The ceiling in the bathroom had 12 splattered drips of a reddish brown substance. These areas remained the same during observations made on 10/04/16 at 9:57 AM and on 10/06/16 during tour at 4:38 PM when the Administrator and Maintenance Director also observed these areas.

m. Room 230, with one resdient residing in this room was observed with 1 of 4 knobs missing from the closet drawers leaving a flat headed screw end extending from the drawer during observations made on 10/05/16 at 11:30 AM, on 10/06/16 at 10:46 AM and on 10/06/16 when the Administrator and Maintenance Director observed the environment beginning at 4:38 PM.

n. An observation made of Room 201, with 1 resident, on 10/03/16 at 2:56 PM revealed the paint looked as if it had been scratched off over bed A and the light fixture over bed A had been replaced with patched unpainted areas around

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the fixture. Additional observation made on 10/06/16 at 11:00 AM revealed the same scratched off paint and unpainted walls over bed A. The Administrator and Maintenance Director also observed these areas when taken on an environmental tour beginning on 10/06/16 at 4:38 PM.

o. An observation made of Room 203, shared by 2 residents, on 10/03/16 at 12:11 PM revealed the paint was scratched off the walls above the A and B beds. Additional observations on 10/05/16 at 8:59 AM and 10/06/16 at 10:00 AM revealed the same scratched off paint above the A and B beds. The Administrator and Maintenance Director also observed these areas when taken on an environmental tour beginning on 10/06/16 at 4:38 PM.

p. An observation made of Room 204, shared by 2 residents, on 10/04/16 at 10:16 AM revealed the paint was scratched off the walls above the A and B beds and painters tape left along the baseboards of the A bed. Additional observations on 10.05/16 at 9:06 AM and 10/06/16 at 9:00 AM revealed the same scratched off paint above the A and B beds and the painters tape along the baseboards of bed A. The Administrator and Maintenance Director also observed these areas when taken on an environmental tour beginning on 10/06/16 at 4:38 PM.

q. Observations of room 132 on 10/03/16 at 2:50 PM revealed a white paint spot approximately six by six centimeters on the outside bathroom wall. Also noted on the same wall was a torn piece of wall paper about three by three centimeters. The corner of the ceiling over the A bed had a dark brown colored stain about six by six centimeters.

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Observations of room 132 on 10/04/16 at 8:44 AM remained unchanged as well as on 10/06/16 at 4:38 PM.

r. Observations of room 128 on 10/03/16 at 3:18 PM revealed a dark brown colored stain approximately six by six centimeters on the ceiling above the bed next to the window. Also noted a white paint spot about six by six centimeters on the room side of the bathroom wall. On 10/04/16 at 8:30 AM the observations of the wall and ceiling remained the same as well as on 10/06/16 at 4:38 PM.

s. Observation of room 108 on 10/03/16 at 4:00 PM revealed a white spot approximately six by six centimeters on the wall directly in front of the bed. The white spot was noted to be on the wall on 10/04/16 at 8:26 AM and 10/06/16 at 4:38 PM.

Interview with the Plant Operations Manager on 10/06/16 at 4:10 PM revealed that he performed a walk through at the end of the day to make sure the repairs he had previously completed were still repaired. He explained that he collected the repair requisitions from the nurses stations every day and took them to the morning meeting. The requisitions were then prioritized by himself and the Administrator in the order of resident safety such as water temperature, wheelchair repairs and walker repairs. He stated the communication slips were kept and filed by the month. The Plant Operations Manager reported that a project that started last summer was mounting new light fixtures above the beds in the residents' rooms. He explained the empty resident rooms were completed first then the residents were asked to move out of their rooms temporarily to complete the occupied rooms. The Plant Operations

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Manager stated the progress had slowed down because he was the only one in the Maintenance Department now along with some help with painting from the floor technician.

On 10/06/16 at 4:38 PM the Administrator and the Plant Operations Manager were accompanied on tour of the facility to review the environmental maintenance concerns. The Plant Operations Manager stated he had already ordered door stops for the doors to prevent them from making the holes in the walls and commented that the blue painters tape must have been overlooked after the painting was completed. Both the Administrator and the Plant Operations Manager stated the exposed screws were a concern.

An interview was conducted with the Administrator on 10/06/16 at 5:30 PM. The Administrator stated the former Maintenance Manager was out from work for several months and the Administrator could not hire for the position. He explained that the issue had been resolved and he could hire for the position now. When the Administrator was asked how he felt about the maintenance concerns brought to his attention during the tour he stated they were concerning but the facility just went through major renovations about two months ago for the Open House and all the rooms were painted and the floors were redone. The Administrator added there were no written plans for further repairs although the Department Heads made rounds of the rooms every day and brought their concerns to the standup meeting in the mornings. He explained that after the meeting the concerns were discussed with the Plant Operations Manager and were prioritized as to which ones to

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F 253	Continued From page 15 work on first. The Administrator stated that the daily rounds made by the Department Heads seemed to be working at the present time and that would continue to be the system used to keep up with the needed repairs. In conclusion of the interview with the Administrator he agreed the residents should not have to live in their rooms in the conditions they were in.	F 253		
F 272 SS=E	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	F 272		11/3/16

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F 272	Continued From page 16 the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to complete Care Area Assessments that addressed the underlying causes and contributing factors for activities of daily living, psychotropic drug use, cognitive loss/dementia, falls, and urinary incontinence and indwelling catheter for 5 of 22 sampled residents (Residents #42, #4, #36, #37, #95). The findings included: 1. Resident #42 was admitted on 10/23/15 with diagnosis including dementia and psychosis. Review of the annual Minimum Data Set (MDS) dated 08/05/16 revealed Resident #42 had unclear speech and was sometimes understood. The annual MDS indicated Resident #42 had short and long-term memory loss and moderately impaired cognitive skills for daily decision making. In addition, annual MDS noted Resident #42 received antipsychotic and antidepressant medications daily during the assessment period. Review of the Care Area Assessment (CAA) Summary for Psychotropic Drug Use dated	F 272	F 272 (E) 1. The following CAAs have all been modified by the MDS Coordinator with oversight by the Clinical Reimbursement Specialist: Resident #4 original CAA 5/2/16 □ ADL CAA modified on 10/27/16 Resident #42 original CAA 8/18/16 □ Psychotropic Drug use CAA modified 10/27/16. Resident #36 original CAA 2/12/16 □ ADL, indwelling catheter, fall and psychotropic drug use CAAs modified 10/28/16. Resident #37 original CAA 4/25/16 □ ADL and Psychotropic drug use CAA modified 10/28/16. Resident #95 original CAA 12/31/15 □ cognitive loss CAA modified on 10/28/16. 2. Active Residents with Comprehensive Assessments and Care Area Assessments (CAAs) completed have the potential to be impacted by the deficient	

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F 272	Continued From page 17 08/18/16 revealed Resident #42 had a diagnosis of psychosis and was at risk for side effects from the psychotropic medications. The CAA Summary noted Resident #42 had no mood or behaviors observed over the past 3 months and was nonverbal with staff. The CAA Summary further revealed had a psychiatric evaluation on 07/28/16 and no referral was needed. The CAA Summary did not state what medications Resident #42 received or note if the psychotropic medications were effective in treating her symptoms. The CAA did not analyze how the psychotropic medications actually affected her day to day function and activities. The CAA Summary also did not indicate if there had been any adverse drug reactions or attempted dose reductions. An interview with MDS Nurse #2 on 10/06/16 at 5:34 PM MDS revealed she had been employed by the facility for three and a half years as a MDS nurse and received periodic training. MDS Nurse #2 stated when she completed an MDS assessment she reviewed the entire medical record for pertinent information, observed the resident, and conducted resident and staff interviews. MDS Nurse #2 indicated none of the MDS training she had attended had ever explained very well what should be included in the CAA Summary and analysis of findings. MDS Nurse #2 confirmed she had completed Resident #42's CAA Summary for Psychotropic Drug Use dated 08/18/16 and stated she should have included more resident specific information in the CAA Summary and analysis of findings. 2. Resident #4 was admitted to the facility on 06/04/15 with diagnosis including diabetes mellitus, hyperglycemia, dysphagia with	F 272	practice. The active residents CAAs completed within the last 30 days will be audited, reviewed and revised as needed by 11/3/16 by the IDT, including DON, ADONs, MDS Coordinators, Quality of Life, SSD and RD to insure they meet the RAI requirements for comprehensive, accurate, standardized reproducible assessment of each resident s functional capacity. If resident is identified to need a significant change in status assessment, it will be scheduled. 3. Training will be completed in accordance with the RAI Manual no later than 10/31/16 through the coordinated effort of the Clinical Reimbursement Specialist and the MDS Success Navigator with Interdisciplinary team members assigned to complete CAAs. Those completing CAA education will be the MDS Coordinators, RD or dietary manager, SSD and Quality of Life Director. Training consists of Chapter 4 of the RAI Manual related to Care Area Assessment process and care planning. Further training on CAAs, care plan development and line by line coding has been made available to the same IDT members through the American Association of Nurse Assessment Coordinators website. 4. The Clinical Reimbursement Specialist will audit 10% of active residents CAAs three times a year to insure continued	

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F 272	Continued From page 18 gastrostomy tube, and anoxic brain injury. Review of the annual MDS dated 04/26/16 revealed Resident #4 was cognitively intact and able to make his needs known. The annual MDS noted Resident #4 required supervision with activities of daily living (ADL) including bed mobility, transfer, walking in his room, toilet use, and bathing. He required limited assistance with dressing and personal hygiene and extensive assistance with eating. The annual MDS further noted Resident #4's balance was not steady but he could stabilize without human assistance. Review of the Care Area Assessment for ADL Functional/Rehabilitation Potential dated 05/02/16 revealed Resident #4 was able to make his needs known and required supervision with ambulation due to unsteady gait and weakness. Risk factors were listed as diabetes mellitus with blood sugar instability and general weakness. It was noted he was currently working with therapy and expected to return to independent level of care. The CAA Summary did not include why he required supervision to limited assistance with most ADL but required extensive assistance with feeding. The CAA summary did not include strengths and weakness or how the triggered area impacted his day to day life. An interview with MDS Nurse #2 on 10/06/16 at 5:34 PM MDS revealed she had been employed by the facility for three and a half years as a MDS nurse and received periodic training. MDS Nurse #2 stated when she completed an MDS assessment she reviewed the entire medical record for pertinent information, observed the resident, and conducted resident and staff interviews. MDS Nurse #2 indicated none of the	F 272	compliance with the plan of correction and RAI requirements as related to CAA completion. The results of these audits will be reviewed in the facility□s QAPI meeting for three audits or one full year for recommendations and further follow-up as indicated. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to insure continued compliance. The QAPI committee consists of the Administrator, DON, SDC, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services and Environmental services. Other members may be assigned as the need arises.	

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MDS training she had attended had ever explained very well what should be included in the CAA Summary and analysis of findings. MDS Nurse #2 confirmed she had completed Resident #4's CAA Summary for ADL Functional/Rehabilitation Potential dated 05/02/16 and stated she should have included more resident specific information in the CAA Summary and analysis of findings.

3. Resident #36 was admitted to the facility on 02/02/16. Her diagnoses included pneumonia, chronic aspiration, hypoxia, atrial fibrillation, diabetes, toxic encephalopathy, acute renal failure, peripheral vascular disease and chronic pain.

Review of the admission Minimum Data Set (MDS) dated 02/09/16 revealed Resident #36 had intact cognition, no mood or behaviors, required extensive assistance with bed mobility, transfers, and toileting, and having an indwelling catheter. She was coded as walking with supervision and one person assist in the room, being unsteady and needing assistance to stabilize herself, having had one fall since admission, and receiving antianxiety medications 7 days in the previous 7 days.

The Care Area Assessments (CAAs) dated 02/12/16 and completed by MDS Nurse #2 did not provide a description of how the triggered areas impacted Resident #36's day to day routines, noted her strengths and weaknesses, or described why the area was a problem for her. Examples included:

a. The Activity of Daily Living CAA stated Resident #36 needed assistance for care at this

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time, was alert and oriented, able to make needs known to staff and had weakness status post hospitalization for a new feeding tube. The CAA stated she would continue to work with therapy with the goal to return to previous independent level.

b. The Indwelling Catheter CAA stated she was at risk for skin breakdown and urinary tract infections related to catheter use. It further stated she was admitted with the catheter, was alert and oriented, and catheter care was performed routinely and it would be evaluated for removal as the physican requested. She showed no signs or symptoms of a urinary tract infection.

c. The Fall CAA stated Resident #36 was able to make her needs known and follow directions without issue. She was noted with weakness after being hospitalized for dysphagia and a new feeding tube placement. She was noted with one fall when she was lowered to the floor during a transfer and she was working with therapy.

d. The Psychotropic Medication CAA stated she was at risk for side effects to medication and had a history of anxiety. She was adjusting well to her short stay and was familiar with staff and routines due to previous stays. The CAA stated psych visits would be offered as needed.

On 10/06/16 at 5:33 PM, MDS Nurse #2 stated she had been with the facility for three and a half years as a MDS nurse and received periodic training. She stated she gathered her MDS information from the medical record, physician notes, staff notes, staff interviews, and will make her own observations. She stated she tried to put all relevant information in the CAA including

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cognition. She further stated that she received little information in exactly what information was to be included in the CAA during any of her training and did not know to describe individual details and paint a picture of how each area impacted a resident's day to day routines. In addition, when asked, MDS Nurse #2 was unable to say why Resident #36 had a catheter at the time of admission.

4. Resident #37 was admitted to the facility on 04/12/16 with diagnoses including pneumonia, end stage renal disease, cerebral vascular disease, major depression and chronic obstructive pulmonary disease.

The admission Minimum Data Set dated 04/19/16 coded her with intact cognition, feeling down and tired, having no behaviors, being nonambulatory, and requiring extensive assistance with most activities of daily living skills. She was also coded receiving dialysis services in the facility and before, and receiving antidepressants and hypnotics 7 days out of the previous 7 days.

The Care Area Assessments dated 04/25/16 and completed by MDS Nurse #2 did not provide a description of how the triggered areas impacted Resident #37's day to day routines, noted her strengths and weaknesses, or described why the area was a problem for her. Examples included:

a. The Activities of Daily Living CAA stated Resdient #37 required extensive assistance with care, was able to make her needs known and had no cognitive deficit noted. She was working with therapy to improve her mobility and strength. The CAA stated she would continue to receive

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the appropriate amount of assistance needed with the goal to return to an independent level of care.

b. The Psychotropic Medication CAA stated she was at risk for side effects to the medication, had no mood or behavior issues at this time and was able to make needs and concerns known. Psych services would be offered as needed.

On 10/06/16 at 5:33 PM, MDS nurse #2 stated she had been with the facility for three and a half years as a MDS nurse and received periodic training. She stated she gathered her MDS information from the medical record, physician notes, staff notes, staff interviews, and will make her own observations. She stated she tried to put all relevant information in the CAA including cognition. She further stated that she received little information in exactly what information was to be included in the CAA during any of her training and did not know to describe individual details and paint a picture of how each area impacted a resident's day to day routines.

5. Resident #95 was admitted to the facility on 08/25/16 with diagnoses including non-Alzheimer's dementia, depression and mood disorder.

Review of the annual Minimum Data Set (MDS) dated 12/22/15 revealed Resident #95 was moderately cognitively impaired and had no mood or behaviors during the seven day look back period.

Review of the Care Area Assessment (CAA) for Psychotropic Drug Use dated 12/31/15 and written by MDS Nurse #2 stated Resident #95 had no mood or behavior issues since

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F 272	Continued From page 23 mid-September when there was an attempted gradual drug reduction. Psychiatry follows resident as needed. Stable at this time on medication regimen, makes needs known without issue. The CAA did not analyze how the psychotropic medications actually affected her day to day function and activities or if they were effective in treating her depression and mood disorder. Review of the CAA for Cognitive Loss/Dementia dated 12/31/15 and written by MDS Nurse #2 stated Resident #95 had dementia and had been stable since previous assessment. Some improvement noted. Pleasant with no mood or behaviors noted over past quarter with psychiatric assessment. The CAA did not analyze how her cognition actually affected her day to day function and activities or if they were effective in treating her depression and mood disorder. During an interview conducted on 10/06/16 at 5:33 PM MDS Nurse #2 stated she had been with the facility for three and a half years as a MDS nurse and received periodic training. She stated she gathered her MDS information form the medical record, physician notes, staff notes, staff interviews, and made observations of the resident. She stated she tried to put all relevant information in the CAA including cognition. She further stated she received little information in exactly what information was to be included in the CAA during any of her training and did not know to describe individual details and paint a picture of how each area impacted a resident's day to day routines.	F 272		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278		11/3/16

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F 278	Continued From page 24 The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to accurately code information on the Minimum Data Sets for 2 of 22 sampled residents whose assessments were reviewed. Resident #54's fall history and Resident #60's eating abilities were coded incorrectly.	F 278	F 278 (D) Modification of the Admission MDS for resident #54 with ARD of 1/21/16 was completed by the MDS Coordinator on 10/06/16 after review of resident chart to reflect accurate coding for fall and fracture	

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F 278	Continued From page 25 The findings included: 1. Resident #54 was admitted to the facility from the hospital on 01/14/16 with diagnoses of a hip fracture, history of falling and seizure disorder. The hospital discharge records for the discharge of 01/14/16 noted that Resident #54 was admitted to the hospital on 01/11/16 following a fall at home and sustaining a non displaced femur fracture. The history and physical completed by the facility's physician dated 01/19/16 also indicated Resident #54 had fallen and had a fractured femur with an open reduction and internal fixation procedure. The admission Minimum Data Set (MDS) dated 01/21/16 coded her with intact cognition, requiring extensive assistance with most activities of daily living skills, being nonambulatory, and having had no falls in the previous month, no falls in the previous 2 to 6 months, and no fractures in the last 6 months. Although the MDS triggered a Care Area Assessment (CAA) relating to falls, review of the CAA dated 01/26/16 revealed only Resident #54's risk for falls was addressed and there was no mention of any actual falls or her hip fracture. On 10/06/16 at 5:33 PM, MDS Nurse #2 stated she had been with the facility for three and a half years as a MDS nurse and received periodic training. She stated she gathered her MDS information form the medical record, physician notes, staff notes, staff interviews, and will make own observations. She stated she tried to put all	F 278	history. The associated CAA dated 1/26/16 was also modified by the MDS Coordinator on 10/27/16. Additionally, after review of the record, modification was completed on the admission MDS (ARD 6/10/16) by the MDS Coordinator on 10/6/16 for resident #60 to reflect accurate coding for the ADL of eating. The associated CAA dated 6/16/16 was modified by the MDS Coordinator on 10/27/16. Comprehensive assessments for residents receiving nutrition via tube and for residents who have had a fall and/or fall with fracture for the past 90 days will be reviewed by the MDS Coordinator, ADON or DON no later than 11/03/16 for discrepancy in coding of self-performance and support provided for eating. Any assessment requiring modification will be completed by the MDS Coordinator and reviewed by the Clinical Reimbursement Specialist and the DON prior to submission to the state. CNAs and MDS Coordinators will receive in service for ADL coding as related to eating ¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿with emphasis on coding residents receiving nutrition via tube no later than 11/3/16. MDS Coordinators will receive additional education for appropriate assessment of each resident no later than 11/3/16. This education will be provided by the Clinical Reimbursement Specialist in collaboration with the MDS Success Navigator. MDS Coordinators will receive education	

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F 278	Continued From page 26 relevant information in the CAA. She further stated that not marking the actual fall and fracture for Resident #53 was an oversight. 2. Resident #60 was admitted on 06/03/16 and his diagnoses included aspiration pneumonia, dysphagia, sepsis, gastroesophageal reflux and pneumonia. The admission Minimum Data Set (MDS) dated 06/10/16 coded him with intact cognition and receiving 51% or more nutrition via a feeding tube. He was coded as needing extensive assistance with eating. Review of the physician orders since admission revealed Resident #60 was never fed any food and received all nutrition via tube. On 10/06/16 at 5:33 PM, MDS Nurse #2 stated she had completed this MDS and that he did not assist with his tube feedings and this was an error in coding the MDS. She further stated that at a meeting in July 2016, this error was pointed out to her but she failed to complete a correction MDS because she did not write the error down to follow up and forgot about it.	F 278	on proper coding of falls and/or falls with fractures no later than 11/3/16. This education will be provided by the Clinical Reimbursement Specialist in collaboration with Pam White, MDS Success Navigator. Audits will be conducted monthly by the Clinical Reimbursement Specialist for the next 3 months to insure compliance with the education provided as well as the accuracy of MDSs prepared and submitted. The facility will audit no less than 10% of the resident population with each audit. There will be a full review of all MDS assessments by the clinical reimbursement specialist prior to submission for the first 30 days of the assessment window. In house audits will be ongoing by the Administrator, DON or ADON with assistance from the clinical reimbursement specialist to insure accuracy of provision of ADLs. MDSs that are in the ARD window are reviewed on week days in clinical white board meeting to assist in decreasing incorrect data entry on the MDS as well as to validate accurate ADL coding in the electronic system. Audit information will be maintained and available for annual state survey. Ongoing audits by MDS Coordinators for accurate ADL coding related to eating will be conducted weekly times two weeks on 3 randomly selected charts then monthly for three months on 5 randomly selected charts. Data will be summarized and presented at the facility QAPI meeting monthly by the MDS Coordinators. Any	

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F 278	Continued From page 27	F 278	issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to insure continued compliance. The QAPI committee consists of the Administrator, DON, SDC, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services and Environmental services. Other members may be assigned as the need arises.	
F 322 SS=E	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by:	F 322		11/3/16

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F 322	Continued From page 28 Based on observations, record reviews and staff interviews the facility failed to administer the Physician ordered tube feeding, failed to flush the feeding tube before starting a tube feeding, failed to dilute a crushed medication before administering via the feeding tube, failed to follow the correct feeding tube flush order and failed to check for residual before starting a feeding for 3 of 4 residents reviewed with feeding tubes (Resident #100, #36 and #60). The findings included: Review of the facility undated policy for Gastrostomy Feeding read in part: · Step #3 - obtain formula to administer and verify the correct formula. · Step #8 - check gastric residual volume before each feeding and flush feeding tube with 30 milliliters (ml) of water Review of the facility Medication Administration Enteral Tubes, taken from Nursing Care Center Pharmacy Policy and Procedure Manual with a copy write date of 2007 read in part: · 2. Prepare medication for administration - a. Consult crush guidelines before crushing tablets. Crush tablets into a fine powder and dissolve in at least 5 milliliters of water or other appropriate liquid. 1. Resident #100 was admitted to the facility on 02/19/16 with diagnoses that included hemiplegia and dysphagia. Review of the quarterly Minimum Data Set (MDS) dated 07/12/16 revealed Resident #100 was	F 322	F322 1. Resident #100 tube feeding of Jevity 1.5 was changed immediately to osmolite 1.5 by Licensed Nurse #4 on 10/5/16. Nurse #4 was re-educated by the Director of Nursing on 10/5/16 and Nurse #3 on 10/7/16 on verifying correct formula and providing the correct type of formula as ordered by the practitioner. Resident #36 Order received on 10/19/16 give 50 ml water flush before and after each tube feed administration four times per day and 10/19/16 osmolite 1.5 ml bolus feeding, give one can (240 ml) of osmolite 1.5 four times per day. No negative outcome were observed related to adding dry crushed medication into the tube and adding 30 ml of water flush; administering extra fluids for the magnesium oxide and not checking residual prior to beginning the flush. Nurse #1 received re-education by Director of Nursing on 10/5/16 for safe and effective administration of enteral formula and medication, including skills validation per facility policy, individualized plan of care and practitioners orders for the resident. Resident #60 no negative outcome were observed. Failed to flush the enteral tube prior to starting the tube feeding. Nurse #2 received re-education on 10/5/16 by the Director of Nursing for safe and effective administration of enteral formula and medication, per facility policy, individualized plan of care and practitioners orders for the resident. 2. Resident with the potential to be	

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F 322	Continued From page 29 moderately cognitively impaired. The MDS further revealed Resident #100 had a feeding tube. Review of the care plan dated 07/21/16 revealed Resident #100 was at risk for nutritional decline related to hyperlipidemia, history of cerebral vascular accident, diabetes, high blood pressure, constipation and difficulty swallowing requiring tube feedings to help meet nutritional needs. He received meal trays for pleasure but refused meals at times. The goal was for Resident #100 to consume 50% of meals offered to him and maintain adequate hydration as evidenced by no signs and symptoms of dehydration through the next review. The interventions included: labs as ordered, provide assistance with eating as needed, speech therapy and treatment as indicated, determine food and beverage preferences, diet as ordered, provide tube feedings and free water flushes as ordered and have the Registered Dietitian (RD) review nutritional status monthly and as needed. Review of the Physician orders revealed the following: · 07/19/16 - give Jevity 1.5 until Osmolite arrives at facility. · 08/10/16 - change tube feeding to Osmolite 1.5 at 70 milliliters per hour for 21 hours and continue water flushes as needed per RD order. An observation made on 10/05/16 at 10:51 AM revealed Resident #100 had Jevity 1.5 hanging for his tube feeding. During an interview conducted on 10/05/16 at 3:13 PM the RD stated Resident #100 should be	F 322	affected. Registered Dietician (RD) and Staff Development Coordinator (SDC) identified and reviewed residents receiving enteral formula to ensure correct formula was being administered, no other residents were found to be affected, this was completed on 10/14/16. Re-education with Licensed Nurses on safe and effective administration of enteral formula and medication per facility policy, including skills validation, practitioners orders for the resident, this was completed 10/26/16. 3. Licensed Nurses received re-education by Director of Nursing and Staff Development Coordinator for safe and effective administration of enteral formula and medication per facility policy, including skills validation, individualized plan of care and practitioners orders for the resident. This included verifying correct formula and providing the correct type of formula as ordered by the practitioner; diluting medication in water; checking for residual; the volume used for flushing including flushing for formula and medication administration; re-education was completed on 10/26/16. This education will be ongoing provided upon hire and annually. 4. The Staff Development Coordinator, Assistant Director of Nursing (ADON), and or Director of Nursing (DON) will audit Licensed Nurses for safe and effective administration of enteral formula and medication per facility policy. 1 nurse daily x 2 weeks, 3 nurses per week x 2	

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F 322	Continued From page 30 receiving Osmolite as his tube feeding. She stated she changed him from Jevity to Osmolite a couple of months ago due to Resident #100 having increased diarrhea from the Jevity. She stated she had written an order in July to allow the facility to use Jevity until the Osmolite came into the facility but wanted Resident #100 switched back to the Osmolite once it arrived. She further stated she expected the facility to call her if there was a need to substitute an ordered tube feeding. An interview conducted on 10/05/16 at 4:48 PM with the Director of Nursing (DON) revealed it was her expectation that tube feeding orders be followed and the correct tube feeding be administered. She stated she went to Resident #100's room on 10/05/16 and found Jevity hanging for his tube feeding and immediately had Nurse #4 change it to Osmolite. An interview conducted on 10/06/16 at 11:54 AM with Nurse #3 revealed she hung the Jevity for Resident #100's tube feeding on the 3:00 PM to 11:00 PM shift on 10/04/16. She stated she looked at the order from 07/19/16 that stated use Jevity until Osmolite comes in to the facility. She stated she had always administered Osmolite in the past. An interview with Nurse #4 on 10/06/16 at 11:11 AM revealed she had provided care for Resident #100 all morning on 10/06/16 and had stopped his tube feeding at 10:00 AM and restarted it at 1:00 PM and did not realize it was Jevity. She stated she knew Resident #100 received Osmolite but had failed to check to make sure the correct feeding was being administered.	F 322	weeks, and 2 nurses weekly x 2 months to ensure compliance. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement (QAPI) committee as they arise and the plan will be revised to insure continued compliance. The QAPI committee consists of the Administrator, DON, SDC, Minimum Data Set (MDS) Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services and Environmental services. Other members may be assigned as the need arises.	

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2. Resident #36 was admitted to the facility on 02/02/16 following a hospitalization for pneumonia, chronic aspiration and new gastrostomy tube placement.

The admission Minimum Data Set (MDS) dated 02/09/16 coded her with intact cognition, receiving tube feedings and a mechanically altered diet.

The quarterly MDS dated 07/22/16 coded her with intact cognition, receiving tube feedings and a mechanically altered diet.

Review of the October 2016 physician orders included the following:
*Osmolite 1.5 one can (240 milliliters) 5 times per day;
*Pureed with honey thickened liquids upon request;
*check tube feeding residual and hold tube feeding if residual greater than 100 ml (milliliters) for one hour;
*flush g-tube (gastrostomy tube) with 30 ml of water before and after medication administration; and
*water flushes 50 cc (cubic centimeters) before and after each bolus tube feed.

a. On 10/05/16 at 12:07 PM, Nurse #1 was observed administering Magnesium Oxide 400 milligrams tablet via g-tube to Resident #36. Nurse #1 crushed the medication and placed the crushed medication in a medicine cup. After checking for placement and residual, Nurse #1 flushed the g-tube with 30 ml of water, added the dry crushed medication into the tube and then added 30ml flush. There was residue of the medication along the side of the g-tube and

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Nurse #1 added an additional 30 ml of water to the tube.

On 10/05/16 at 2:28 PM Nurse #1 stated that there was no problem with administering the extra fluids with the Magnesium because Resident #36 was not on a fluid restriction and was permitted free thickened liquids throughout the day. She stated she normally diluted the Magnesium Oxide with water before the administration but it still required extra water to flush it down the g-tube on a regular basis. Nurse #1 further stated that she did not ever think to inform the Physician or Registered Dietitian of the need to administer extra fluids for the Magnesium Oxide since Resident #36 was not on a fluid restriction.

b. On 10/05/16 at 12:48 PM, Nurse #1 removed the remainder of the meal tray of pleasure foods from Resident #36 who had just drank some fluids and ate the desert. Nurse #1 proceeded to check for placement via auscultation and then flush with 45 ml of water. Nurse #1 did not check for residual until the flush failed to run through the g-tube. Nurse #1 then checked for residual, obtained over 100 ml, re-administered the residual, then flushed with 45 ml and discontinued the administration of tube feeding.

Immediately following the attempt to administer the tube feeding, Nurse #1 and the surveyor checked the orders via the nurses' computer. On the screen for this medication pass revealed no flush orders. Nurse #1 stated she used 45 ml because she asked the Staff Development Coordinator and Director of Nursing what to do about the flushes and that is what she was told. Further review revealed the flush orders for 50 ml before and after the g-tube feeding was on the

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screen for the 11:30 AM medication pass and not with the tube feeding medication pass.

On 10/05/16 at 2:28 PM, Nurse #1 stated she made a mistake when she did not check for residual prior to beginning the flush for the g-tube feeding administration and that the 2 different computer screens (one time for flush and one time for the tube feeding) confused her.

On 10/06/16 at 11:42 PM an interview was conducted with the Director of Nursing (DON). DON stated that she expected the nurses to dilute the Magnesium Oxide in water prior to pouring into the tube for administration. She stated the resident was not on a fluid restriction and drank fluids freely so additional water was not an issue. The DON stated she expected nurses to check for residual prior to the flushing a g-tube and administering the tube feeding.

3. Resident #60 was admitted to the facility on 06/06/16. His diagnoses included aspiration pneumonia and required tube feedings for all nutrition.

His admission Minimum Data Set (MDS) dated 06/10/16 coded him as having intact cognition and receiving nutrition via tube.

The quarterly MDS dated 09/09/16 coded him with severely impaired cognition and receiving nutrition via tube.

Review of the October 2016 physician orders included the following:
*Flush with 30 milliliters (ml) of water before and after start of tube feeding;
*Flush g-tube with 90 mls of water every hour

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F 322	Continued From page 34 during feed, on at 6:00 PM and off at 8:00 AM; and *Jevity 1.5 at 90 ml for 14 hours on at 6:00 PM and off at 8:00AM. On 10/05/16 at 6:10 PM Nurse #2 was observed setting up and administering Resident #60 the nightly tube feeding. Nurse #2 entered with a new bag and tubing for the water flushes which were automatic with the tube feeding and the tube feeding formula. He proceeded to fill the water bag and hang the tube feeding, threading the tubing through the tube feeding pump. He primed the machine to ensure the feeding traveled through the end of the tube which he capped and set aside. Nurse #2 proceeded to check placement through auscultation and then checked for residual. Nurse #2 immediately connected the tube feeding to Resident #60's gastrostomy tube and turn on the machine setting the machine for 90 ml tube feeding and 90 ml flushes every hour. Nurse #2 failed to flush the tube prior to starting the tube feeding. On 10/05/16 at 6:21 PM, Nurse #2 stated that he should have flushed the tube prior to starting the feeding and stated he was nervous and forgot. The Director of Nursing stated on 10/06/16 at 11:47 AM during interview that she expected nurses to flush the tube as ordered prior to the administration of formula.	F 322		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services:	F 328		11/3/16

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F 328	Continued From page 35 Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews and resident interview, the facility failed to securely store an oxygen tank and maintain the flow rate of oxygen per physician orders for 2 of 4 sampled residents using oxygen (Resident #36 and #111). The findings included: 1. Resident #36 was admitted to the facility on 02/02/16 with diagnoses including pneumonia, chronic aspiration, acute respiratory failure, chronic obstructive pulmonary disease and hypoxia. The admission Minimum Data Sets (MDS) dated 02/09/16 and the quarterly MDS dated 07/22/16, coded her with intact cognition and receiving oxygen therapy. Review of October 2016 physician orders included the treatment order with an original date of 02/02/16 for oxygen at 2 liters per minute (LPM) continuously via nasal cannula. On 10/03/16 at 11:56 AM, Resident #36 was observed in bed with oxygen being administered	F 328	F328 =D Treatment / Care For Special Needs (O2 Use) " Oxygen tank from room 210-A from Resident # 111 was promptly removed and was placed at the designated place on 10/3/16 by the Director of Nursing assisted by the Certified Nursing Assistant. Oxygen order was checked for resident #36 on 10/6/16. Oxygen concentrator for resident #36 was promptly adjusted by Nurse #1 per MD order at 2L/min. " On October 4, 2016 DON, SDC and ADON made rounds to resident□s room at the facility to ensure all Oxygen cylinders were secured. All Oxygen in use were all secured and none were found to be affected by the deficient practice. Residents using Oxygen were identified on October 7, 2016. DON, SDC, ADON reviewed oxygen orders and oxygen in use were audited for correct oxygen flow rate. Audit completed on October 7, 2016. All residents using Oxygen were receiving the correct Oxygen flow rate as ordered by MD and none were found to be affected by the deficient practice.	

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F 328	Continued From page 36 via an oxygen concentrator which was set at 3 LPM. On 10/04/16 at 3:23 PM, she was observed in bed asleep with oxygen being administered via an oxygen concentrator at 3 LPM. On 10/05/16 at 9:40 AM, Resident #36 was observed in bed with oxygen being administered at 3 LPM via the oxygen concentrator. She stated at this time that she used oxygen continuously at 3 LPM. Resident #36's oxygen was observed being administered at 3 LPM on 10/05/16 at 5:43 PM. The oxygen being administered to Resident #36 via oxygen concentrator was again observed set and running at 3 LPM on 10/06/16 at 10:54 AM. Nurse #1 who worked with Resident #36 all week during first shift was interviewed on 10/06/16 at 10:56 AM. Nurse #1 stated that the oxygen was to be administered at 2 LPM per physician orders which she also checked in the computer. Nurse #1 indicated it was the responsibility of the nurses to check residents' oxygen settings every shift. Nurse #1 stated that she had not checked it yet this date. Nurse #1 stated that about 3 times per week she needed to reset the setting on the oxygen concentrator and recalled doing so on Monday. Nurse #1 stated that when she found the oxygen not set correctly she just passed it on to the next shift to watch it. She further stated that she has told Resident #36 the oxygen setting needed to be at 2 LPM to which the resident stated she did not mess with the settings and could not keep the orders straight in her head.	F 328	" On 10/6/16 Staff Development Coordinator and Director of Nursing educated Nursing Staff in regards to oxygen storage, following oxygen orders and monitoring the Oxygen settings every shift. All residents requiring oxygen were identified. Staff Development re-educated all Licensed Nurses and Certified Nursing Assistants in regards to oxygen storage, educated Licensed Nurses on following oxygen orders and the importance of checking Oxygen settings for accuracy every shift. Re-education was completed on 10/24/16. Education of securely storing oxygen tank(s) will be ongoing for Certified Nursing Assistant and Licensed Nurses upon hire and as needed, as well as monitoring of oxygen setting per MD order will continue during orientation for newly hired licensed Nurses and as needed. " An audit consisting of ten residents will be monitored by Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator and Licensed Nurses to ensure continued compliance for securely stored oxygen tanks and the flow rate of oxygen per physician orders per day for 2 weeks, then 6 residents daily X 4 weeks and 3 residents per week x 3 months. Director of Nursing will report observation results at the monthly Quality Assurance Performance Improvement Committee for continued compliance and/ or revision. Any trends identified will be addressed to ensure continued compliance.	

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The Director of Nursing stated during interview on 10/06/16 at 11:46 AM that the nurses should check the oxygen settings every shift and she would expect to hear if there was a problem keeping the setting at the physician ordered rate of administration.

During interview with Resident #36 on 10/06/16 at 2:26 PM, Resident #36 denied ever changing the settings on the oxygen concentrator.

2. Resident #111 was admitted to the facility on 05/07/16 with diagnoses that included chronic obstructive pulmonary disease.

Review of the admission Minimum Data Set dated 05/07/16 revealed Resident #111 was cognitively intact and required the use of oxygen.

An observation made during the initial tour of the building on 10/03/16 at 9:30 AM revealed an unsecured oxygen cylinder standing on the floor against the wall beside a secured oxygen cylinder on a rolling cart in Resident #111's room.

An interview conducted on 10/03/16 at 12:52 PM with Resident #111 revealed the oxygen cylinder had been in his room a couple of days sitting on the floor and unsecured. He stated staff left it there when they changed it to a full tank and had not picked it up yet.

During an interview conducted on 10/03/16 at 1:00 PM Nurse Aide (NA) #1 stated the Director of Nursing (DON) found they unsecured oxygen cylinder in Resident #111's and asked her to take it to the oxygen storage room. She stated an oxygen cylinder should never be left in a resident's room unsecured.

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F 328	Continued From page 38 During an interview conducted on 10/04/16 at 3:08 PM the DON stated she was making rounds on 10/03/16 and found the unsecured oxygen cylinder in Resident #111's room. She stated she asked NA #1 to take the oxygen cylinder to the oxygen storage room. She stated oxygen cylinders should never be left in a resident's room unsecured.	F 328		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview and family interviews, the facility failed to provide routine dental services for 1 of 4 sampled residents reviewed for dental status and services (Resident #60). The findings included: Resident #60 was admitted to the facility on 06/06/16. His diagnoses included aspiration pneumonia and he required tube feedings for all nutrition.	F 412	F412 The Responsible Party of resident #60 was contacted by the Licensed Nurse on 10/24/2016 for consent for the resident to be seen and preference of dental care provider. The Resident Representative stated that she prefers that the resident not be sent to a dental care provider outside of the facility. She further stated that since the resident denies any pain or discomfort at this time that she wanted the resident to be scheduled for a dental	11/3/16

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F 412	Continued From page 39 His admission Minimum Data Set (MDS) dated 06/10/16 coded him as having intact cognition, receiving nutrition via a feeding tube and having obvious or likely cavity or broken natural teeth. The Dental Care Area Assessment (CAA) completed by MDS Nurse #2 and dated 06/16/16 noted that Resident #60 was at risk for poor dentition, had some broken teeth and no referral was needed. The CAA continued stating that he was tube fed, had no intake by mouth, he was assisted with oral care, and would be offered dental evaluations as needed. Review of a care plan dated 06/13/16 and last updated 09/09/16 addressing nutritional risk included a noted dated 06/16/16 that said the resident had some broken teeth and had stable weight. Ongoing interventions for Resident #60 included dental exam as needed. The quarterly MDS dated 09/09/16 coded Resident #60 with severely impaired cognition and receiving nutrition via a feeding tube. On 10/3/16 at 11:48 AM, Resident #60 was observed with many missing teeth. A family interview conducted on 10/04/16 at 9:27 AM revealed that Resident #60 only had 4 natural teeth and to family's knowledge had not seen a dentist since admission. Review of the medical record revealed no evidence that Resident #60 had been seen by a dentist since his admission on 06/06/16. Interview with the Social Worker (SW) on	F 412	exam on the facility□s dental care provider□s next visit. The Social Services Director contacted the facility□s dental care provider on 10/27/2016 to add the resident to the list to be seen on the next visit on 11/17/2016. Residents in the facility have the potential to be affected by the deficient practice. An audit was completed on 10/07/2016 to identify any current resident who has not been seen by the dental services provider in the facility. All residents who have not been seen by the Dental Care Provider will be placed on the list for exam on the next visit by 11/03/2016 as desired and appropriate. All Comprehensive assessments with CAA documentation will be audited for any resident who needs to be referred to the Dentist by 11/03/2016. Education will be provided to the MDS Coordinators related to accurate assessment of dental status, CAA documentation and subsequent referral for dental care as indicated. Education will be provided by the MDS Success Navigator no later than 10/31/2016. Resident□s dental status will be reviewed quarterly by the MDS Coordinator with referral to Social Services Director and the Dental Care Provider as indicated. CAA documentation will continue to be completed yearly by the MDS Coordinator with referral for dental services forwarded to the Social Services Director as indicated. Residents who exhibit pain, discomfort, or nutritional decline related to dentition with be referred to a Dental Care	

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F 412	Continued From page 40 10/06/16 at 12:03 PM revealed the facility had arrangements with a dentist to see all residents at least once a year for a dental exam. In addition, there was a second dental group that came every 3 to 4 months to follow up on residents and see residents for ongoing care as needed. SW stated that when a new resident was admitted, she relied on the nurses to inform her if a resident needed to be seen for dental care. The second dental group came 06/22/16 and was scheduled to come 10/07/16. Per SW, Resident #60 was not on either list to be seen. The last time the dentist came for the yearly visit was in March prior to Resident #60's admission. SW stated she was not informed that Resident #60 needed to see a dentist. MDS Nurse #1 stated during interview on 10/06/16 at 11:13 PM that if she noted poor dentition on her assessments, she would make a referral to the social worker so that the resident would be seen by a dentist. An interview on 10/06/16 at 5:33 PM with MDS Nurse #2, who completed the admission MDS assessment revealed that she understood that all long term care residents were seen by a dentist annually and was unaware that if she noted problems that she should inform the SW who would see that the resident was seen before the next annual visit. Interview with the Director of Nursing (DON) on 10/06/16 at 6:19 PM revealed that a dentist conducted an annual oral exam on all residents once a year and another group came and saw residents in between and as needed. She stated that the MDS nurse was responsible for letting the SW know when someone needed to see the	F 412	Provider as soon as possible following consent of responsible party. Documentation of the dental visit will be maintained in each resident□s medical record. DON, SDC, ADON and or Licensed Nurses will monitor 10% of all Quarterly and Comprehensive assessments that are completed each week for accuracy of dental coding and need for referral to Dental Care Provider. Monitoring will be completed weekly x 2 weeks then monthly x 3 months. Monitoring will continue quarterly thereafter. Data will be summarized and presented at the facility QAPI meeting monthly by the DON. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to insure continued compliance. The QAPI committee consists of the Administrator, DON, SDC, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services Director.	

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F 412	Continued From page 41 dentist. The SW would then obtain a physician's order and the resident would be seen the next time the dental group came or if needed be sent out for more immediate dental care. The DON stated Resident #60 should have been seen by a dental group before this date.	F 412		
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 record reviews and staff interviews the facility failed to maintain complete and accurate diet orders on the Physician's order sheets (Residents #36 and #60) and document a resident's fall in the nurse's progress notes (Resident #66) for 3 of 23 sampled residents. The findings included: 1. Resident #36 was admitted to the facility on 02/02/16 following a hospitalization for pneumonia, chronic aspiration and new	F 514	Preparation and/ or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/ or solely because it is required by the provisions of Federal and State Law. 1. Resident # 36 Enteral Feeding was verified and transcribed by Staff Development Coordinator (SDC) as	11/3/16

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F 514	Continued From page 42 gastrostomy tube placement. The admission Minimum Data Set (MDS) dated 02/09/16 coded her with intact cognition, receiving tube feedings and a mechanically altered diet. The quarterly MDS dated 07/22/16 coded her with intact cognition, receiving tube feedings and a mechanically altered diet. Review of the October 2016 Physician's Order Sheet (POS) included the resident's name, date of birth, date of admission, drug allergies, diagnoses and diet in a squared off section in the middle of each page. Resident #36's diet was listed as puree with honey thickened liquids, Jevity 240 milliliters (ml) bolus, pleasure pureed textures, honey thick liquids upon request. Located in the section with medications and treatments was the following in later pages: *Osmolite 1.5 one can (240 ml) 5 times per day; *Pureed with honey thickened liquids upon request; *check tube feeding residual and hold tube feeding if residual greater than 100 ml (milliners) for one hour; *flush g-tube with 30 mls of water before and after medication administration; and *water flushes 50 cc before and after each bolus tube feed. There was no indication in this section related to puree pleasure foods or honey thick liquids. On 10/06/16 at 11:49 PM the Director of Nursing (DON) was interviewed. She stated that she expected nurses to update orders and diets as physician orders were obtained. She further stated there were two computer screens that	F 514	ordered on 10/12/16. Physician□s Order Sheet now indicate, 1. Osmolite 1.5 Bolus Feeding, Give one can (240 ml) of Osmolite1.5 4X Daily. 2. Water Flush, Give 50 ml water before and after each tube feed administration: 0800, 1200, 1600, 2000. At the bottom of the Physician□s Order Sheet now show the Diet Order: Puree (pleasure foods) with honey thick Liquids. Resident # 60 order was reviewed, verified and transcribed as ordered on 10/12/16 by SDC. Physician□s Order Sheet now indicate Jevity 1.5 at 90 ml/hour for 14 hours on at 1800, off at 0800. Diet order indicate Nothing by Mouth (NPO). Resident #36 and resident # 60 received the correct Feeding formula as ordered in the Physician□s Order Sheet and correct diet as ordered on 10/6/16. 2. Registered Dietician (RD) and SDC identified residents receiving Tube feeding. SDC and RD reviewed and verified Tube Feeding and Diet orders for residents receiving Tube feeding on October 12, 2016 for accuracy. Verified MD orders for Tube Feeding and Diet orders processed and completed on 10/12/16. 3. On 10/25/16 to 10/28/16 Director of Nursing (DON) and SDC re-educated all licensed staff regarding policy, procedures and appropriate way of transcribing Tube feeding and Diet orders. New tube feeding orders will be reviewed at the daily Clinical meeting by DON, Assistant Director	

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F 514	Continued From page 43 addressed the POS information. Tube feedings were noted under one screen and the nurse would have to access an ancillary screen to change the box which included the resident's diet. The physician orders screen would be the screen that appeared on the Medication Administration Record for nurses. DON stated both screens should have been updated with correct, consistent diet orders. 2. Resident #60 was admitted to the facility on 06/06/16. His diagnoses included aspiration pneumonia and required tube feedings for all nutrition. The admission Minimum Data Set (MDS) dated 06/10/16 coded him as having intact cognition and receiving nutrition via tube. The quarterly MDS dated 09/09/16 coded him with severely impaired cognition and receiving nutrition via tube. Review of the October 2016 Physician's Order Sheet (POS) included the resident's name, date of birth, date of admission, drug allergies, diagnoses and diet in a squared off section in the middle of each page. Resident #60's diet was listed nothing by mouth (NPO), Jevity 1.5 at 45 ml (milliliters) per hour and 30 ml of water an hour for flushes. Located in the section with medications and treatments was the following: *Flush G tube with 90 mls of water every hour during feed on at 6:00 PM and off at 8:00 AM;and *Jevity 1.5 at 90 mls for 14 hours on at 6:00 PM and off at 8:00AM. This section did not say he was not able to take anything by mouth.	F 514	Nursing and SDC for accuracy and compliance. Weekly meeting with Registered Dietician (RD), DON, ADON and SDC will continue to review Tube feeding and Diet orders to ensure compliance. New hired licensed staff will be educated during their orientation in regards to Tube Feeding and Diet orders policies and procedures. 4. DON and ADON will report trends identified from Tube Feeding and Diet orders processes at the monthly Quality Assurance Performance Improvement Committee (QAPI) for three months for continued compliance and /or revision. 1. On 8/25/16, Resident #66 was trying to wheel onto the elevator and wheel chair got caught on the elevator threshold causing wheel chair to flip backwards. Resident was observed on his back in front of the elevator with no injuries noted for over 72 hours. Resident is alert and oriented and able to express his needs and feelings. Resident was evaluated by Rehab Department on 8/26/16 and was recommended to install anti- tippers on the back of his wheel chair. He was also educated on 8/26/16 by Director of Nursing (DON) not to push himself backwards when coming out from the elevator. Resident expressed understanding and agreement with intervention for safety. 2. Fall incidents are reviewed and investigated daily at the Clinical meeting	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345162	A. BUILDING _____ B. WING _____	C 10/06/2016

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F 514	Continued From page 44 On 10/06/16 at 11:49 PM the Director of Nursing (DON) was interviewed. She stated that she expected nurses to update orders and diets as physician orders were obtained. She further stated there were two computer screens that addressed the POS information. Tube feedings were noted under one screen and the nurse would have to access an ancillary screen to change the box which included the resident's diet. The physician orders screen would be the screen that appeared on the Medication Administration Record for nurses. DON stated both screens should have been updated with correct, consistent diet orders. 3. Resident # 66 was admitted to the facility on 01/01/16 with diagnoses which included bilateral above the knee amputations and chronic obstructive pulmonary disease. Review of the quarterly Minimum Data Set dated 08/19/16 revealed Resident #66 was cognitively intact and had no falls during the look back period. Review of the care plan dated 08/25/16 revealed Resident #66 was at risk for fall related injury due to bilateral above the knee amputation, new prosthesis, psychotropic/anxiety medication usage and use of wheel chair. 08/25/16 wheel chair tipped backwards while getting off the elevator. The goal was for Resident #66 to not sustain a fall related injury by utilizing fall precautions through the next review. The interventions included: report falls, observe for medication side effects and report to physician,	F 514	by the Interdisciplinary Team Members. Resident□s care plan are reviewed and updated with new interventions if appropriate when fall incident occur. Appropriate referral to Rehab Department is initiated for evaluation if appropriate. Daily documentation of observation of resident after a fall per shift will be monitored for 72 hours by DON, Assistant Director of Nursing (ADON) and Staff Development Coordinator (SDC) if there is no injury to ensure compliance. 3. On 10/12/16 to 10/16/16, licensed staff were educated by SDC in regards to Falls Policy and Procedures. Education of Falls Policy and Procedures will continue during orientation for newly hired licensed Staff and as needed. 4. Monitoring Tool was initiated to review daily observation and documentation of the resident for any signs of pain and discomforts status post fall for 72 hours if there is no injury. 2 residents with fall incidents will be reviewed for observation and documentation daily x 2 weeks and then 3 residents per week for three months. DON or ADON will report trends identified from report audits to monthly Quality Assurance Performance Improvement Committee for three months for continued compliance and/ or revision. Any issues noted will be addressed to ensure continued compliance.	

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F 514	Continued From page 45	F 514		

provide call light within reach, adequate glare-free lighting, monitor use of adaptive devices, splint/brace, wheelchair, bilateral leg prosthesis and educate resident not to push self-off backwards from the elevator, referred top rehabilitation to install ant-tippers to wheelchair.

Review of the facility Investigation Report dated 08/25/16 at 1:00 PM revealed Resident #66 was trying to wheel onto the elevator and the wheel on the wheelchair got caught on the elevator threshold causing the wheelchair to flip backwards. The report stated Resident #66 was found on his back in front of the elevator with no injuries noted. The question on the report - Charting completed every shift for 72 hours was answered yes. The investigation report was completed by Nurse #1.

Review of the nurse's notes from 08/24/16 through 09/28/16 revealed no documentation of Resident #66's fall from wheelchair on 08/25/16 or follow up assessment of Resident #66 for 72 hours after the fall.

During an interview conducted on 10/06/16 at 8:20 AM Nurse #1 stated she completed the investigation report for Resident #66's fall on 08/25/16. She stated she did not witness the fall but she did assess Resident #66 after the fall and he had no apparent injuries or complaints.

During an interview conducted on 10/06/16 at 11:44 PM the Director of Nursing (DON) stated any resident fall should be documented in the nurse's notes and the resident should be assessed for 72 hours after the fall with the assessment documentation in the nurse's notes.

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F 514	Continued From page 46 A follow up interview conducted with Nurse #1 on 10/06/16 at 12:18 PM revealed she did assess Resident #66 after his fall on 08/25/16 but did not document the assessment in the nurse's notes. She stated she had been told the investigation report was sufficient documentation. Nurse #1 stated the resident should be assessed for 72 hours after a fall and that assessment should be documented in the nurse's notes. She stated she didn't realize she had not documented fall assessments for Resident #66 after his fall on 08/25/16.	F 514		