STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345304	A. BUILDING _____ B. WING _____	C 09/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER NURSING CARE/SHAM	2727 SHAMROCK DRIVE CHARLOTTE, NC 28205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to empty and clean a bedside commode that contained urine in 1 resident bathroom (Room #209), failed to label bedpans and bath basins in 2 resident bathrooms (Room # 203 and #213) and failed to cover a toilet plunger that was in a urine collection container next to a toilet or label a urinal with a resident name in 1 resident bathroom (Room #216) on 1 of 3 resident hallways (200 Hall) and failed to repair 16 resident bathroom doors with broken and splintered laminate and wood (Resident room #112, #116, #202, #203, #204, #205, #208, #209, #210, #211, #213, #215, #216, #309, #312 and #313) on 3 of 3 resident hallways (100, 200 and 300 halls). The findings included: 1. a. Observations on 09/28/16 at 4:43 PM in the bathroom of Room #209 revealed a bedside commode with dark urine in the bottom of the bucket and the bathroom had a strong odor of old stale urine. Observations on 09/29/16 at 3:48 PM in the bathroom of Room #209 revealed a bedside commode with dark urine in the bottom of the bucket and the bathroom had a strong odor of old stale urine. Observations on 09/30/16 at 11:06 AM in the	F 253	Brian Center Shamrock acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct in order to maintain compliance with applicable rules and provisions of Quality of Care of residents This Plan of Correction is submitted as a written allegation of compliance. Preparation and submission of this plan of correction is in response to CMS 2567 from the survey conducted on 9/26/16 – 9/30/16. Brian Center Shamrocks responses to the cited deficiencies do not denote agreement with the statement nor does it constitute an admission that any deficiency is accurate. Further, Brain Center Shamrock reserves the right to refute any deficiency on this statement through Informal Dispute Resolution, formal appeal, and/or other administrative or legal procedures. F253 – Housekeeping and Maintenance Services Criteria 1.	10/28/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/24/2016

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

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F 253	Continued From page 1 bathroom of Room #209 revealed a bedside commode with dark urine in the bottom of the bucket and the bathroom had a strong odor of old stale urine. b. Observations on 09/28/16 at 4:37 PM in the bathroom of Room #203 revealed a bath basin in a clear plastic bag on the floor next to the toilet with no resident name on it and a bedpan was in a clear plastic bag on top of the bath basin with no resident name on it. Observations on 09/29/16 at 3:42 PM in the bathroom of Room #203 revealed a bath basin in a clear plastic bag on the floor next to the toilet with no resident name on it and a bedpan was in a clear plastic bag on top of the bath basin with no resident name on it. Observations on 09/30/16 at 11:01 AM in the bathroom of Room #203 revealed a bath basin in a clear plastic bag on the floor next to the toilet with no resident name on it and a bedpan was in a clear plastic bag on top of the bath basin with no resident name on it. c. Observations on 09/28/16 at 4:47 PM in the bathroom of Room #213 revealed a bath basin in a clear plastic bag hanging from a metal handrail with no resident name on it. Observations on 09/29/16 at 3:53 PM in the bathroom of Room #213 revealed a bath basin in a clear plastic bag hanging from a metal handrail with no resident name on it. Observations on 09/30/16 at 11:23 AM in the bathroom of Room #213 revealed a bath basin in a clear plastic bag hanging from a metal handrail with no resident name on it. d. Observation on 09/28/16 at 4:49 PM in the bathroom of Room #216 revealed a toilet bowl	F 253	A. Room #209 the bedside commode was immediately cleaned and returned to the room by the Housekeeping Supervisor. Room #203 and #213 the bedpans, bath basins were immediately removed and they were replaced with labeled and bagged bedpans and bath basins at the appropriate bedside by the Director of Nursing. Room #216 toilet plunger and urine collection container were immediately removed from the bathroom by the Housekeeping Supervisor. Completed on 9/30/2016. B. Corrective action was accomplished for the alleged deficient practice by the Maintenance Director coordinating the repair schedule for the identified resident doors by 10/28/2016. Criteria 2. A. Any resident in the facility has the potential to be affected by this alleged deficient practice. An audit of all rooms was completed by the Director of Nursing, Assistant Director of Nursing, Unit Manager and Housekeeping Supervisor to ensure all bed pans and bath basins are labeled and bagged for storage, bedside commodes are cleaned following use and toilet plungers are not stored in resident bathrooms. This audit was completed on 10/19/2016. B. All residents residing in the building have the potential to be affected by this alleged deficient practice. An audit of all resident room doors was conducted by the Maintenance Director and Division	

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F 253	Continued From page 2 plunger was sitting inside a plastic urine collection container on the floor next to the toilet and was not covered. A urinal was observed hanging from a metal handrail in the bathroom and did not have a resident name on it. Observation on 09/29/16 at 3:55 PM in the bathroom of Room #216 revealed a toilet bowl plunger was sitting inside a plastic urine collection container on the floor next to the toilet and was not covered. A urinal was observed hanging from a metal handrail in the bathroom and did not have a resident name on it. Observation on 09/28/16 at 11:24 AM in the bathroom of Room #216 revealed a toilet bowl plunger was sitting inside a plastic urine collection container on the floor next to the toilet and was not covered. A urinal was observed hanging from a metal handrail in the bathroom and did not have a resident name on it. During an interview on 09/30/16 at 11:31 AM with Nurse Aide (NA) #4 she stated staff were expected to label resident's bedpans and bath basins with the resident's name and they should be stored in a plastic bag and they were not supposed to be left on the floor in the bathroom. During an interview on 09/30/16 at 11:40 AM with NA #5 she stated staff were supposed to write the residents name on bedpans and put them in a plastic bag and store them in the resident's closet. During an interview and tour on 09/30/16 at 11:50 AM with the Assistant Director of Nursing she stated staff were expected to label bedpans and bath basins with the resident's name and they should be stored in the resident's closet or drawer in their room. She verified the bedpan and bath	F 253	Maintenance Director by 10/19/2016. A prioritized repair schedule was developed and implemented by the Division Maintenance Director by 10/28/2016. Criteria 3. A.The Director of Nursing, Housekeeping Supervisor, Staff Development Nurse, Assistant Director of Nursing, Unit Manager and Administrator will re-educate all facility staff regarding labeling and bagging bedpans and bath basins, methods for cleaning resident equipment following use and the process for requesting maintenance needs. This education will be completed on 10/28/2016. A.The Director of Nursing, Housekeeping Supervisor or Administrator will randomly review 10 resident rooms per week for 12 weeks to validate bed pans and bath basins are labeled and bagged, resident equipment is cleaned following use and no toilet plungers are stored in the resident bathrooms. Opportunities will be corrected as identified. B. All Staff will be re-educated by the Maintenance Director, Administrator, DON, or ADON on recognizing and reporting maintenance request for needed repairs. This education will be completed by 10/28/2016. The Maintenance Director will monitor the doors weekly for twelve weeks to identify any needed repairs and	

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F 253	Continued From page 3 basin in room 203 did not have a resident's name written on them and they should not have been stored on the bathroom floor. She also stated bedside commodes should be emptied, cleaned and wiped out. She explained housekeeping had a cleaner staff could use to clean out the bedside commodes. She acknowledged the bedside commode in room 209 should have been emptied and was unacceptable for urine to be left inside it. She stated toilet bowl plungers should be stored in a plastic bag in the resident rooms. She confirmed the toilet bowl plunger in the bathroom of Room #216 should have been covered with a plastic bag and should not have been stored in a urine collection container and confirmed the urinal was not labeled with a resident's name. During an interview on 09/30/16 at 2:31 PM with the Director of Nursing she stated she expected staff to label bedpans and bath basins with the resident's name and urinals could be bagged and stored in the bathroom but needed to be labeled with the resident's name. She explained bedpans and bath basins should be stored in the residents' personal space on their side of the room. She stated she expected staff to check bedside commodes every shift and empty the contents and clean them. She further stated if the bedside commode was badly soiled, nursing staff could ask housekeeping to take them out for a thorough cleaning. She explained toilet bowl plungers should be stored in plastic bags and should not be stored in urine collection containers on the bathroom floor. She stated she did not realize toilet bowl plungers were on the resident hallways in resident bathrooms. 2. a. Observations of Room #112 on 09/28/16 at 4:39 PM revealed the bathroom door of the	F 253	maintenance concerns. Opportunities will be corrected as identified. Criteria 4. A.The Director of Nursing and Administrator, will report monitoring results to the QAPI committee for three months, quarterly, and then as needed. The QAPI committee will make recommendations as required. Date of Compliance is 10/28/16 B. Measures to ensure that corrections are achieved & sustained include: The results of results of door repairs and monitoring will be submitted to the QAPI Committee by the Maintenance Director for review by IDT members each month. The QAPI committee will evaluate the effectiveness and amend as needed. Date of Compliance is 10/28/16	

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resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/29/16 at 3:55 PM revealed the bathroom door of resident room #112 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/30/16 at 10:55 AM revealed the bathroom door of resident room #112 had broken and splintered laminate on the edges of the bottom half of the door.

b. Observations of Room #116 on 09/28/16 at 4:40 PM revealed the bathroom door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/29/16 at 3:39 PM revealed the bathroom door of resident room #116 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/30/16 at 10:56 AM revealed the bathroom door of resident room #116 had broken and splintered laminate on the edges of the bottom half of the door.

c. Observations of Room #202 on 09/28/16 at 4:41 PM revealed the bathroom door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/29/16 at 3:41 PM revealed the bathroom door of resident room #202 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/30/16 at 11:00 AM revealed the bathroom door of resident room #202 had broken and splintered laminate on the edges of the bottom half of the door.

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F 253	Continued From page 5 d. Observations of Room #203 on 09/28/16 at 4:42 PM revealed the bathroom door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 09/29/16 at 3:42 PM revealed the bathroom door of resident room #203 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 09/30/16 at 11:01 AM revealed the bathroom door of resident room #203 had broken and splintered laminate on the edges of the bottom half of the door. e. Observations of Room #204 on 09/28/16 at 4:43 PM revealed the bathroom door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 09/29/16 at 3:43 PM revealed the bathroom door of resident room #204 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 09/30/16 at 11:02 AM revealed the bathroom door of resident room #204 had broken and splintered laminate on the edges of the bottom half of the door. f. Observations of Room #205 on 09/28/16 at 4:44 PM revealed the bathroom door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 09/29/16 at 3:44 PM revealed the bathroom door of resident room #205 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 09/30/16 at 11:03 AM revealed	F 253		

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the bathroom door of resident room #205 had broken and splintered laminate on the edges of the bottom half of the door.

g. Observations of Room #208 on 09/28/16 at 4:45 PM revealed the bathroom door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/29/16 at 3:47 PM revealed the bathroom door of resident room #208 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/30/16 at 11:05 AM revealed the bathroom door of resident room #208 had broken and splintered laminate on the edges of the bottom half of the door.

h. Observations of Room #209 on 09/28/16 at 4:46 PM revealed the bathroom door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/29/16 at 3:48 PM revealed the bathroom door of resident room #209 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/30/16 at 11:06 AM revealed the bathroom door of resident room #209 had broken and splintered laminate on the edges of the bottom half of the door.

i. Observations of Room #210 on 09/28/16 at 4:47 PM revealed the bathroom door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/29/16 at 3:50 PM revealed the bathroom door of resident room #210 had

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broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/30/16 at 11:07 AM revealed the bathroom door of resident room #210 had broken and splintered laminate on the edges of the bottom half of the door.

j. Observations of Room #211 on 09/28/16 at 4:48 PM revealed the bathroom door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/29/16 at 3:51 PM revealed the bathroom door of resident room #211 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/30/16 at 11:22 AM revealed the bathroom door of resident room #211 had broken and splintered laminate on the edges of the bottom half of the door.

k. Observations of Room #213 on 09/28/16 at 4:49 PM revealed the bathroom door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/29/16 at 3:52 PM revealed the bathroom door of resident room #213 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/30/16 at 11:23 AM revealed the bathroom door of resident room #213 had broken and splintered laminate on the edges of the bottom half of the door.

l. Observations of Room #215 on 09/28/16 at 4:50 PM revealed the bathroom door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.

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F 253	Continued From page 8 Observations on 09/29/16 at 3:54 PM revealed the bathroom door of resident room #215 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 09/30/16 at 11:24 AM revealed the bathroom door of resident room #215 had broken and splintered laminate on the edges of the bottom half of the door. m. Observations of Room #216 on 09/28/16 at 4:51 PM revealed the bathroom door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 09/29/16 at 3:55 PM revealed the bathroom door of resident room #216 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 09/30/16 at 11:25 AM revealed the bathroom door of resident room #216 had broken and splintered laminate on the edges of the bottom half of the door. n. Observations of Room #309 on 09/28/16 at 4:52 PM revealed the bathroom door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 09/29/16 at 3:57 PM revealed the bathroom door of resident room #309 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 09/30/16 at 11:26 AM revealed the bathroom door of resident room #309 had broken and splintered laminate on the edges of the bottom half of the door. o. Observations of Room #312 on 09/28/16 at 4:53 PM revealed the bathroom door of the	F 253		

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resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/29/16 at 3:58 PM revealed the bathroom door of resident room #312 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/30/16 at 11:27 AM revealed the bathroom door of resident room #312 had broken and splintered laminate on the edges of the bottom half of the door.

p. Observations of Room #313 on 09/28/16 at 4:54 PM revealed the bathroom door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/29/16 at 3:59 PM revealed the bathroom door of resident room #313 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 09/30/16 at 11:28 AM revealed the bathroom door of resident room #313 had broken and splintered laminate on the edges of the bottom half of the door.

During an environmental tour and interview on 09/30/16 at 3:00 PM with the Administrator she stated she did not have a Maintenance Director at the present time but a Maintenance Director and his assistant from another facility in the company had been providing maintenance services 4-5 hours a day for 5 days a week until a new Maintenance Director was hired. She explained the facility had a book for staff to document maintenance concerns that was kept at the nurse's station and they also used a work order request program in the computer system and staff were trained to access and document

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F 253	Continued From page 10 maintenance concerns and she managed those maintenance issues. She verified during the tour the bathroom doors had damage to the laminate on the lower half of the edges of the doors. She stated it was her expectation for staff to report maintenance issues and to report damage to resident doors. She further stated she also expected for housekeepers to report damage to resident doors because they were in and out of the rooms routinely. She explained she felt the doors should be repaired by sanding and placement of wood putty in the deep areas where laminate and wood was missing.	F 253		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who 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	F 278		10/28/16

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F 278	Continued From page 11 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 observation, resident an staff interviews, and record review, the facility failed to accurately code the Minimum Data Set assessments regarding vision and provide documentation related to verbal behaviors for 2 of 28 sampled residents (Residents #48 and #37). The findings included: 1. Review of Resident #48's annual Minimum Data Set (MDS) dated 08/30/16 revealed an assessment of intact cognition. The MDS indicated Resident #48's vision was impaired with no corrective lenses. Interview on 09/28/16 at 2:51 PM with Resident #48 revealed she used glasses for reading. Resident #48 explained staff members assisted in retrieval of the glasses from a basket placed on the bedside table. Observation on 09/28/16 at 2:55 PM revealed Resident #48's glasses in a basket near the bedside. Interview on 09/30/16 at 9:31 AM with MDS Coordinator #1 revealed MDS Coordinator #2 completed Resident #48's annual MDS. MDS Coordinator #1 reported the MDS was incorrectly coded and MDS Coordinator #2 was not available	F 278	F278 – Assessment Accuracy/Coordination/Certified Criteria 1. The MDSs for Resident #48 with ARD 8/30/16 and #37 with ARD 8/26/16 were corrected by MDS coordinator on 10/28/2016. Criteria 2. All residents have the potential to be affected by this alleged deficient practice. The Resident Care Management Director and MDS Coordinator conducted an audit of all MDSs completed during the last 30 days to validate accurate coding of visual acuity and behaviors. This audit was completed by 10/28/2016. Criteria 3. The Division Director of Care Management will re-educate the MDS Department regarding accurate completion of the MDS regarding assessment of visual acuity. The RCMD will re-educate the Social Services Director regarding documentation and coding of behaviors on MDS. This	

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F 278	Continued From page 12 for interview. Interview with the Administrator on 09/30/16 at 9:37 AM revealed the MDS should be accurately coded to reflect Resident #48's use of corrective lenses. 2. Resident #37 was admitted to the facility on 06/19/15. Diagnoses included mental disorder due to physiological conditions. Review of a quarterly Minimum Data Set (MDS), dated 08/26/16, revealed Resident #37 was assessed in section E0200, Behavioral Symptom Presence and Frequency, as displaying verbal behavioral symptoms directed towards others. This behavior was assessed as occurring 4 - 6 days during the assessment reference review period of 08/19/16 - 08/26/16. Review of Resident #37's medical record and behavior monitoring revealed there was no documentation regarding Resident #37's verbal abuse during the MDS assessment reference review period of 08/19/16 - 08/26/16. During an interview on 09/30/16 at 3:22 PM, the Social Worker (SW) stated that she completed section E, Behaviors on the quarterly MDS dated 08/26/16 for Resident #37. The SW further stated that Resident #37 was care planned for verbal behaviors, she had witnessed this behavior, but she could not recall specific dates. The SW stated that she did not review his medical record or interview staff when she completed this section of the MDS. The SW stated she was not sure this behavior occurred for Resident #37 during the assessment reference window of the MDS, but that she based the assessment on his current care plan. During an interview on 09/30/16 at 4:14 PM, the Director of Nursing stated that she expected	F 278	education was completed by 10/28/2016. The Resident Care Management Director will randomly audit 5 completed MDSs per week to validate accurate coding of the visual acuity assessment and behaviors weekly for 12 weeks. Opportunities will be corrected as identified. Criteria 4. Director of Nursing, Administrator, and/or designee will report monitoring results to the QAPI committee for three months, quarterly, and then as needed.	

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F 278	Continued From page 13 documentation to be in place to support resident behavior coded on the MDS.	F 278		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, the facility failed to assess facial grimacing and yelling during wound care as possible signs and symptoms of pain and assess the effectiveness of pain medication administered prior to wound care for a confused resident for 1 of 4 sampled residents reviewed for pain management (Resident #63). The findings included: Resident #63 was admitted to the facility on 01/09/13 and re-admitted on 05/31/16 with a sacral pressure ulcer. Additional diagnoses included dementia, cerebral artery occlusion, attention/concentration deficit, and cerebral infarction. Medical record review revealed Resident #63 had a current physician's order which was originally initiated on 11/16/15 to observe for pain each shift, if pain is present, complete pain flow sheet	F 309	F309 Criteria 1. The Charge Nurse immediately ensured that resident #63 was properly medicated for pain and assessed for effectiveness of pain medication on 9/28/16. Criteria 2. Any current resident receiving wound care has the potential to be affected by this alleged deficient practice. The Director of Nursing, Assistant Director of Nursing, and Unit Manager will complete an audit of current medication administration records for residents receiving wound care to ensure physician's orders are in place for pain management by 10/28/2016.	10/28/16

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F 309	Continued From page 14 and try treating with non-pharmacologic interventions prior to medication if appropriate. A physician's order dated 07/12/16 was written for Tramadol HCL 50 mg to be administered every 6 hours as needed for pain. A quarterly MDS dated 09/02/16 assessed Resident #63 as rarely/never understood/understands, adequate hearing, severely impaired cognition, no behaviors, required total staff assistance with bed mobility, extensive staff assistance with transfers, received pain medication as needed or was offered and declined, unable to answer if pain was present, staff observed non-verbal sounds (facial expressions) to indicate pain in the last 5 days, staff observed indicators of pain or possible pain for 3-4 days and an unhealed stage 4 pressure ulcer. Review of Resident #63's care plan dated 09/02/16 identified the Resident with impaired cognitive function, required extensive to total staff assistance with activities of daily living (ADL) and received wound care due to a stage 4 sacral pressure ulcer. Interventions included to ask yes/no questions to determine needs, ensure effective pain management prior to ADL/wound care activities, to provide medications as ordered and observe/document effectiveness. Review of the Resident's Medication Administration Record revealed Tramadol was administered to Resident #63 in September 2016 as follows: · 09/01/16, pain level 9, medication noted as effective · 09/01/16, pain level 3, medication noted as	F 309	Criteria 3. The Director of Nursing or Staff Development Nurse will re-educate Licensed Nurses regarding administration of physician ordered pain medication to ensure effective assessment and intervention to manage pain while providing wound care. This re-education will be completed by 10/28/2016. The Director of Nursing, Assistant Director of Nursing, and/or Unit Manager will randomly observe 3 residents receiving wound care weekly for 12 weeks to verify administration of pain medication and assessment and intervention of pain during wound care. Opportunities will be corrected as identified. Criteria 4. Director of Nursing, Administrator, and/or designee will report monitoring results to the QAPI committee for three months, quarterly, and then as needed. The QAPI committee will make recommendations as required.	

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effective
· 09/02/16, pain level 3, medication noted as effective
· 09/05/16, pain level 5, medication noted as effective
· 09/09/16, pain level 3, medication noted as effective
· 09/12/16, pain level 2, medication noted as effective

Resident #63 had a wound consult by the physician on 9/12/16. The consult assessed Resident #63 with a healing stage 4 sacral pressure ulcer, which measured 5.2 cm by 5.3 cm by 0.4 cm, undermining of 3.5 cm at 2 o'clock, and 100% granulation tissue. Nurses reported to the physician that Resident #63 was sitting up most of the day. There was increased drainage noted on the dressing with slight maceration of the peri-wound tissues. The treatment was changed to cleanse sacral wound with wound cleaner, pat dry, apply calcium alginate dressing and cover with a dry protective dressing once daily.

A physician's order dated 09/28/16 was obtained for Resident #63 to receive Tylenol 325 mg every 4 hours as needed for pain.

An observation of wound care occurred on 09/28/16 at 1:45 PM. The Assistant Director of Nursing (ADON) was present during the wound care. Nurse #1 and NA #1 transferred Resident #63 from her wheel chair to her bed. Resident #63 was observed to yell out and grimace. Nurse #1 stated that she medicated Resident #63 with 2 Tylenol 325 mg "about 30 minutes ago." Nurse #1 wiped down the over bed table, placed the items for the dressing change on the over bed table,

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performed hand hygiene, donned gloves and stated "I am going to look at her wound." Nurse #1 removed an intact dressing dated 09/27/16; Resident #63 yelled out. NA #1 asked Resident #63 if she was okay, the Resident replied "Yes." Nurse #1 sprayed the wound with wound cleanser and used a 4 by 4 cm gauze to cleanse the wound. Resident #63 yelled out. Nurse #1 stated to Resident #63 "I am just cleaning your wound, are you ok?" Resident #63 did not respond. NA #1 asked Resident #63 if her bottom hurt, Resident #63 replied "Yes." NA #1 stated "We are almost done." Nurse #1 used a 4 by 4 cm gauze to pat the wound dry, placed calcium alginate to the wound and measured the amount of calcium alginate needed according to the size of the wound. Resident #63 yelled out. NA #1 asked Resident #63 if she was okay; the Resident did not respond. NA #1 asked the Resident if she was in pain, the Resident replied "Yes." The surveyor asked Resident #63 if she was in pain and NA #1 asked the Resident if her bottom hurt, Resident #63 replied "Yes." NA #1 stated to the Resident "The nurse is almost finished." Nurse #1 applied the calcium alginate to the wound bed, covered it with a dry dressing, dated the dressing and positioned Resident #63 off her bottom with a wedge cushion. Nurse #1 asked the Resident if she was okay, the Resident replied "Yes."

During an interview with Nurse #1 on 09/28/16 at 2:05 PM, she stated "This was my first time giving wound care to this Resident." Nurse #1 stated that Resident #63 had a physician's order for Tramadol HCL 50 mg every 6 hours as needed for pain, but that she did not administer it because the family requested to only give Tramadol if the Resident was in excruciating pain. Nurse #1 stated the only way she would know if

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the Resident was in excruciating pain was if the Resident grimaced or yelled out. Nurse #1 stated that Resident #63 could not verbally rate her pain. Nurse #1 stated she administered 2 Tylenol 325 mg instead of the Tramadol, but that she did not think the Tylenol was effective since Resident #63 yelled out and grimaced. Nurse #1 stated that Resident #63 yelled out and grimaced when she was transferred from her wheel chair to the bed, but that she does that all the time when repositioned. Nurse #1 further stated that she did not assess the effectiveness of the Tylenol after administration and stated that when Resident #63 yelled out/grimaced during wound care "I should have assessed the effectiveness of the Tylenol, assessed her pain and then given the Tramadol."

An interview with NA #1 occurred on 09/28/16 at 2:28 PM and revealed that she routinely worked with Resident #63 for the past month. NA #1 stated that Resident #63 often cried out when she was being repositioned, and usually denied pain, but "today she hollered out and her face looked like she was in pain." NA #1 stated "We should have stopped the care and let her calm down before proceeding and made sure she was comfortable." NA #1 stated Resident #63 would say simple things like yes/no.

During an interview with the ADON on 09/28/16 at 4:52 PM she stated that she provided wound care to Resident #63 a few times before and stated "She does not typically complain of anything during wound care." The ADON stated that based on where she was standing in the room, she could not see Resident #63's face during the wound care. The ADON further stated that she did not hear Resident #63 yell out during wound

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care, and further stated "If the nurse heard this I would expect her to stop care, assess the effectiveness of pain medication and see if the Resident had a physician's order for something stronger or call the physician to get an order so that the Resident would be comfortable." The ADON also stated that the nurse should assess the effectiveness of pain medication 1 - 2 hours after administration and before wound care to make sure the Resident was comfortable.

During a telephone interview on 09/28/16 at 6:04 PM, the wound physician stated that if Resident #63 showed signs of pain, the nurse should stop the care and assess for pain. The wound physician further stated that when the Resident's wound was debrided she did express some discomfort which was managed topically. The wound physician stated that if a resident shows signs of pain with wound care, the resident should be assessed and given something to make them comfortable before continuing the care.

During an interview on 09/29/16 at 4:14 PM, the Director of Nursing (DON) stated that Resident #63 could not rate her pain on a pain scale, so staff looked for grimacing/crying to determine the Resident's level of pain. The DON stated that with each administration of pain medication she expected the nurse to wait at least 30 minutes after administration and assess the effectiveness. The DON stated that Resident #63 could not complain of pain, "she does not answer appropriately", but if the nurse identified what she thought might be pain, the nurse should stop care and assess to determine if the resident was truly in pain.

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F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to keep side rails secured putting the resident at risk for entrapment for 1 of 29 sampled residents (Resident #15). The findings include: Resident #15 was admitted on 01/26/16 with the diagnoses included hypertension, peripheral vascular disease, diabetes, anxiety, depression, chronic obstructive pulmonary disease, and respiratory failure. The most recent quarterly Minimum Data Set (MDS) dated 06/29/16 indicated the resident's cognition was intact. She required supervision with bed mobility and transfers. An observation was made 09/28/16 at 10:03 AM of the right half side rail. The rail was tested for security. The rail was loose and able to be pulled 1 to 2 inches away from the bed. The left side of the bed was against the wall and the left rail was in the low position. An interview was conducted with the resident on 09/28/16 at 10:04 AM. She indicated the right half side rail has been loose since she was admitted. The resident stated she used the rail to move up in the bed. She stated no one had	F 323	F323 – Free of Accident Hazards/Supervision/Devices Criteria 1. The bed for resident #15 was replaced with a new bed with properly functioning side rails by the Maintenance Director on 9/30/16. Criteria 2. All residents have the potential to be affected by this alleged deficient practice. An audit of all side rails will be conducted by the Maintenance Director by 10/28/2016. Side rails that are loose or improperly functioning will be repaired by 10/28/2016. Criteria 3. The Administrator, Director of Nursing, Assistant Director of Nursing or Maintenance Director will re-educate all staff on the proper functioning of side rails	10/28/16

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F 323	Continued From page 20 tightened the rails. An observation was made 09/29/16 at 9:39 AM of the right half side rail. The rail was tested for security. The rail was loose and able to be pulled 2 to 3 inches away from the bed. The left side of the bed was against the wall and the left rail was in the low position. An interview on 09/29/16 at 2:19 PM with medication aide #1 revealed medication aide #1 was unaware the resident ' s right half side rail was loose. An interview on 09/29/16 at 2:22 PM with nurse aide (NA) #3 revealed NA #3 was unaware the resident's right half side rail was loose. An observation was made on 09/30/16 at 9:41 AM of the right half side rail. The rail was tested for security. The rail was loose and able to be pulled 2 to 3 inches away from the bed. The left side of the bed was against the wall and the left rail was in the low position. On 09/30/16 at 2:52 PM the administrator observed both half side rails. The administrator tested the rail for security. The rail was loose and able to be pulled 1 to 2 inches away from the bed. The administrator stated a family member made her aware of the loose rail on 09/29/16. The maintenance assistant tightened the rails on 09/29/16. The administrator also stated the whole bed would be replaced. An interview on 09/30/16 at 5:00 PM with the administrator revealed the maintenance director was responsible for checking side rails monthly. The administrator stated the last check of side rails was completed on 09/15/16. Staff are expected to write in the maintenance request book if loose side rails are found.	F 323	and the process for completion of maintenance request forms to notify the maintenance department of needed repairs. This re-education will be completed by 10/28/2016. The Maintenance Director or Administrator will audit the side rails of 10 residents per week for 12 weeks to ensure these side rails are not loose or in need of repair. Opportunities will be corrected as identified. Criteria 4. Director of Nursing, Administrator, or Maintenance Director will report monitoring results to the QAPI committee for three months, quarterly, and then as needed. The QAPI committee will make recommendations as required.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		10/28/16

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F 371	Continued From page 21 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, resident interview (Resident #8), staff interview and facility record review, the facility failed to store perishable foods (chicken salad, tuna salad, egg salad, deli sandwich meat) with a label and date of storage, sausage patties in a closed container, remove expired bananas from dry storage, store hot foods for the tray line service to prevent the potential growth of bacteria and use clean utensils to plate foods during the tray line service for Resident #114. The findings included: 1. During the initial facility kitchen tour on 09/26/16 from 10:41 AM - 11:25 AM, the following concerns were noted in cold and dry storage: · The walk-in refrigerator was observed with a case of sausage patties in a plastic bag stored inside a cardboard box. The plastic bag and box lid were open and the sausage patties were observed open to air. · The cook's reach-in cooler was observed with plastic containers of chicken salad and egg salad, and 10 slices of deli meat covered with plastic	F 371	F371 Corrective action was accomplished for the alleged deficient practice by the Dietary Manager coordinating the following for Food Procure, Store/Prepare/Serve-Sanitary: Criteria 1. Any residents have the potential to be affected by this alleged deficient practice. An immediate audit for proper dating and labeling food items and removal of over ripened produce by Dietary Manager to determine if any other residents are affected. Completed 9/30/16 Criteria 2. The District Manager re-educated the Dietary Manager on timely completion of Food Procure, Store/Prepare/Service-Sanitary. All Staff re-educated by the District Manager and Dietary Manager on Food Storage Label/Date before placing in Reach-in Cooler, Walk-in Cooler, Freezer and	

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F 371	Continued From page 22 wrap without a date of storage. Tuna salad was stored in a plastic container with a use by date recorded as "09/24/16". · The dry storage room was noted with a case of bananas each with dark colored patches and exposed banana. There was a strong odor of ripe bananas in the dry storage room. During an interview on 09/26/16 at 11:15 AM, the Food Service Director (FSD) stated that she was responsible for monitoring cold and dry storage areas daily for labeling/dating of foods and expired items. The FSD stated that all perishable foods should have a date of storage and be stored in sealed containers. The FSD also stated that the bananas would be discarded, but had no explanation as to why the bananas still remained in dry storage. During a lunch meal dining observation on 09/26/16 at 1:30 PM, Resident #8 stated that she requested bananas with each meal and received an "old banana with lots of specks" that morning (09/26/16). Resident #8 further stated that she did not eat the banana because she did not want a banana that looked like that. An interview on 09/30/16 at 4:16 PM with the Administrator revealed she expected dietary staff to meet all federal regulations in that department. 2. On 09/26/16 at 10:45 AM the steam table was observed with the temperature dial set to "10" (the highest setting) with the following foods stored, covered with a lid and steam escaping: · Sliced ham, (2 inch, long stainless steel pan) · Turnip greens, (4 inch, short stainless steel pan); stored in a steam table well with steam escaping and space available for other pans	F 371	Storage Room. All Staff re-educated on fresh produce for serving ripe produce. All Staff re-educated by the District Manager and Dietary Manager on Food Prep Temperature; Food prepared for meal service to be put in steam table no more than 30 minutes prior to service. All Staff re-educated by the District Manager and Dietary Manager on cross contamination from the bacteria transferred from one substance to another with harmful covering the essentials of hand washing, donning new gloves and separate utensils for each food item. Completed 9/30/16 Criteria 3. Dietary Manage will monitor the Reach-in Cooler, Walk-in Cooler, Freezer and Storage Room daily for 3 months, Administrator will monitor the Reach-in Cooler, Walk-in Cooler, Freezer and Storage Room 3X weekly for 3 months and District Manager will monitor weekly for 3 months. Opportunities will be corrected as identified. Dietary Manager will monitor food prep /temperatures for each meal service daily for 3 months, Administrator will monitor 3x weekly for 3 months and District Manager weekly for 3 months. Opportunities will be corrected as identified. Dietary Manager will monitor hand washing with daily random audits on each	

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	345304	A. BUILDING _____ B. WING _____	C 09/30/2016

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F 371	Continued From page 23 · Carrot coins (1/3 stainless steel pan); stored in a steam table well with steam escaping and space available for other pans · Ham, mechanical soft (1/3 stainless steel pan); stored in a steam table well with steam escaping and space available for other pans · Ham, pureed (1/3 stainless steel pan); stored in a steam table well with steam escaping and space available for other pans · Turnip greens, pureed (1/3 stainless steel pan); stored in a steam table well with steam escaping and space available for other pans · Pinto beans, pureed (1/3 stainless steel pan); stored in a steam table well with steam escaping and space available for other pans During an interview on 09/26/16 at 10:45 AM, dietary staff (DS) #1 stated that she began her lunch meal preparation at about 08:30 AM for a lunch meal tray line service that would begin at 11:45 AM or 12 noon. DS #1 further stated that the lunch meal items were stored on the steam table for "almost an hour" because there were only "2 staff this morning so I had to try to get things done." She expressed that on occasion she stored foods on the steam table more than 30 minutes prior to the tray line service whenever there were only 2 dietary staff in the kitchen to prepare the meal. An interview on 09/26/16 at 10:48 AM with the Food Service Director (FSD) revealed that her typical staffing pattern for the breakfast/lunch meal was 1 cook and 2 dietary aides (DA), but that one of the DA was running late that day. The FSD stated that this happened on occasion and caused the FSD to have to "pitch in" to help the cook and remaining DA complete breakfast and lunch tasks. The FSD stated she was not aware	F 371	shift for 3 months, Administrator will monitor the random audits 3X weekly for 3 months, and District Manager will monitor audits weekly for 3 months. Opportunities will be corrected as identified. Completed 10/24/16 Criteria 4. Administrator, District Manager and Dietary Manager to ensure that corrections are achieved & sustained include: Report the monitoring results be submitted to the QAPI Committee for review by IDT members each month for 3 months. The QAPI committee will evaluate the effectiveness and amend as needed. Reporting the monitoring results to QAPI will be on going. Completed 10/24/16	

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that the steam table should not be used for hot holding more than 30 minutes prior to the meal service.

An interview with the Food Service District Manager (FSDM) occurred on 09/26/16 at 12:11 PM and revealed that she had identified a concern with labeling/dating of perishable foods during her rounds. The FSDM stated she placed the dietary department on a plan of correction, but that the FSD had some staffing issues and at times the FSD had to help with kitchen tasks which interfered with her ability to complete monitoring for the plan of correction. The FSDM stated when she conducted rounds, she monitored for foods stored on the steam table more than 30 minutes before the tray line began, but had not advised the FSD of this expectation.

An interview on 09/30/16 at 4:16 PM with the Administrator revealed she expected dietary staff to meet all federal regulations in that department.

3. An observation of the lunch meal tray line service occurred on 09/30/16 from 11:17 AM - 12:20 PM. During the observation, Dietary Staff (DS) #2 was observed, while wearing gloves to pick the cord of the lowerator (plate storage) off the floor and wrapped it around the lowerator. The cord was observed covered with dust and debris. While wearing the same gloves, DS #2 plated hush puppies for Resident #114 without changing gloves or performing hand hygiene. The lunch meal for Resident #114 was placed on the delivery cart for delivery to the Resident.

An interview on 09/30/16 at 12:10 PM with the Food Service Director (FSD) revealed DS #2

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F 371	Continued From page 25 should have changed her gloves and performed hand hygiene after she picked the cord to the lowerator off the floor. The FSD was observed to instruct DS #2 to discard the lunch meal for Resident # and re-plate the meal. An interview on 09/30/16 at 4:16 PM with the Administrator revealed she expected dietary staff to meet all federal regulations in that department.	F 371		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	F 520		10/25/16

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F 520	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions the committee put into place in November, 2015. This was for a recited deficiency which was originally cited during the facility's current recertification survey completed on 11/05/15. The deficiency was in the area of food sanitation. The facility also failed to maintain implemented procedures and monitor these interventions put into place after a complaint investigation completed on 03/23/16. The deficiency was in the area of provision of care and services to maintain well-being. The continued failure of the facility during three federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: F 309: Based on observation, staff interviews and medical record review, the facility failed to assess facial grimacing and yelling during wound care as possible sign and symptoms of pain and assess the effectiveness of pain medication administered prior to wound care for a confused resident for 1 of 4 sampled residents reviewed for pain management (Resident #63). The facility was recited for F 309 regarding failure to assess symptoms of pain during a dressing change and effectiveness of pain medication. F 309 was originally cited during a survey	F 520	F520 1.Corrective action was accomplished for the alleged deficient practice by the Administrator holding an Ad Hoc QAPI meeting on 10/17/2016 to discuss the outcomes of the annual survey and potential repeat citations of F309 related to resident pain assessment and F371 related to kitchen sanitation. The Interdisciplinary Department Head Team reviewed the previous plan of correction related to resident assessment and kitchen sanitation. 2.Any current resident receiving wound care has the potential to be affected by this alleged deficient practice. The Director of Nursing, Assistant Director of Nursing, and Unit Manager will complete an audit of current medication administration records for residents receiving wound care to ensure physician's orders are in place for pain management by 10/28/2016. 3.The Interdisciplinary Department Head Team were re-educated by the Director of Nursing and the Administrator regarding the regulatory requirement for F309 Maintaining Resident Well-being and F371 Kitchen Sanitation. This education was completed by 10/17/16. The Administrator will hold a weekly Ad Hoc QAPI committee meeting to review F309 Maintain Resident Well-being and F371 Kitchen sanitation to ensure all regulatory aspects are addressed and in compliance.	

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F 520	Continued From page 27 completed on 03/23/16 for failure to promptly provide medical care for a resident with a fracture. F 371: Based on observation, resident interview (Resident #8), staff interviews and facility record review, the facility failed to store perishable foods (chicken salad, tuna salad, egg salad, deli sandwich meat) with a label and date of storage, sausage patties in a closed container, remove expired bananas from dry storage, store hot foods for the tray line service to prevent the potential growth of bacteria and use clean utensils to plate foods during the tray line service for Resident #144. The facility was recited for F 371 regarding failures in food storage, hot food item time on the tray line and lack of clean utensil use. F 371 was originally cited during a recertification survey completed on 11/05/15 for failure to date leftover food, discard food items not used within 48 hours per facility policy and failure to tightly close, label and date food items in the freezer. F 520: Based on observations, staff interviews and record review, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions the committee put into place in November, 2015. This was for a recited deficiency which was originally cited during the facility's current recertification survey completed on 11/05/15. The deficiency was in the area of food sanitation. The facility also failed to maintain implemented procedures and monitor these interventions put into place after a complaint investigation completed on 03/23/16. The deficiency was in the area of provision of care	F 520	Opportunities will be corrected as identified. 4.Measures to ensure that corrections are achieved & sustained include: The results of these weekly meetings will be submitted to the QAPI Committee by the Administrator for review by IDT members each month. The QAPI committee will evaluate the effectiveness and amend as needed. Date of compliance is 10/25/16	

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F 520	Continued From page 28	F 520		

and services to maintain well-being. The continued failure of the facility during three federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program.

The facility was recited for F 520 regarding failures to correct deficiencies cited during a recertification survey in the areas of pain assessment and food sanitation. F 520 was originally cited during a recertification survey completed on 11/05/15 for failure to maintain an effective quality assurance program regarding food sanitation.

Interview with the Administrator on 09/30/16 at 4:28 PM revealed the facility's Quality Assurance Committee met regularly. The Administrator reported the facility did not identify lack of pain assessments as a concern. The Administrator reported food storage areas received inspections on a regular basis by the dietary manager and district dietary manager. The Administrator explained the monitoring of food sanitation continued with items corrected.