STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345163	A. BUILDING _____ B. WING _____	C 02/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENBRIDGE HEALTH AND REHABILTATION CENTER	211 MILTON BROWN HEIRS ROAD BOONE, NC 28607

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the Complaint Investigation. Event ID # H6U711.	F 000		
F 248 SS=D	483.24(c)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES (c) Activities. (1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and resident interviews the facility failed to provide an ongoing activities program, which included in room activities for 1 of 3 sampled residents reviewed for activities (Resident #6). The findings included: Resident #6 was admitted to the facility on 2/14/03 and readmitted 1/12/17 after hospitalization with diagnoses which included: multiple sclerosis, macular degeneration, hypertension, heart failure, diabetes, osteoporosis, chronic asthma, depression, dependence on oxygen, and lower extremity edema. A review of an Annual Minimum Data Set (MDS)	F 248	Glenbridge Nursing and Rehabilitation Center acknowledges receipt of the statement of Deficiencies and proposes this Plan of Correction to the ectent that the summay of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The plan of correction is submitted as a written allegation of compliance. Glenbridge Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Glenbridge Nursing and Rehabilitation	2/27/17

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

Electronically Signed | 02/27/2017

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F 248	Continued From page 1 assessment dated 11/25/16 indicated that Resident #6 was interviewed for interest in activities. In response to the question "How important is it to you to listen to music you like?" the resident had responded, "Somewhat important". The Annual MDS assessment indicated that the resident was cognitively impaired. The 11/25/16 assessment indicated the resident required extensive assistance for bed mobility, dressing, and personal hygiene. The same assessment indicated that the resident required a wheel chair for locomotion and had impaired range of motion of arms and legs. The Annual MDS assessment dated 11/25/16 also revealed that Activities did trigger as an area to be considered for Care Planning. Comments entered by the staff indicated that the Resident has always done things with family or in small groups and she is uncomfortable around groups. An Activities Review Progress note dated 1/18/17 indicated that Resident #6 was bedbound and needed in room visits. A review of the Care Plan for Resident #6, which was dated from the readmission date of 1/12/17 and had a target date of 03/13/17, revealed that the resident enjoyed talking to family on the phone and listening to music. The Care Plan also stated that the resident had little or no out of the room activity involvement related to diagnosis of Multiple Sclerosis. The Intervention that was on the Care Plan was for the activity staff to continue to invite resident to activities and provide in room visits as well. A review of the Activity Log for Resident #6 for November 2016, December 2016, and January 2017 revealed that the resident had in room visits	F 248	reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F 248 Activities What Measures did the facility put in place for the resident affected: On 02-17-17, The Social Worker had a Bird Feeder placed outside Resident Window. On 2/17/17 an activities assessment was completed. What measures were put in place for residents having the potential to be affected: On 02-17-17. The Activity Director and Activity Department were in-serviced on in room activities for Residents who prefer or can□t come to group activities. On 02/22/17, the Activity Director Started 100% audit of all residents on one on one for Residents Choices of Activities it will be completed by 2/27/17. What systems were put in place to prevent the deficient practice from reoccurring: On 02-17-17. The Activity Director and Activity Department were in-serviced on in room activities for Residents who prefer or can□t come to group activities. All Residents with in room visits were	

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F 248	Continued From page 2 by activity staff on Nov 1, Nov 3, Nov 6, Nov 10, Nov 15, and Nov 16 (Total of 6 visits). The Activity Log for December indicated that in room visits had been made with Resident #6 on Dec 1, Dec 7, Dec 12, Dec 14, Dec 19, Dec 21, Dec 23, Dec 25, and Dec 29 (Total of 9 visits). During January the resident was hospitalized from 01/07/17 through 01/12/17 and received in room visits on Jan 1, Jan 4, Jan 6, Jan 13, Jan 19, Jan 21, Jan 23, and Jan 29. (Total of 8 visits). The schedule for in room visits was reviewed. Resident #6 was on the schedule to have in room visits three times per week, on Monday, Wednesday, and Friday. On 02/01/17 at 9:08 AM Resident #6 was observed sleeping in bed, blinds on window drawn, lights on that side of the room were dimmed. There was no music playing in the resident's room. On 02/01/17 at 10:00 PM Resident #6 was observed sleeping in bed, with window blind drawn, lights dimmed on that side of the room. An activities staff member was observed walking down the hall and invited residents to Bible Study and Music activity scheduled to begin at that time. Resident #6 was not invited to attend the activity. The TV was turned off and no other activity going on in the resident's room. On 02/01/17 at 2:24 PM Resident #6 was observed resting in bed, lights off in the room. There was no music playing or other activity taking place in the resident's room. On 02/02/17 at 4:27 PM Resident #6 was observed lying in bed and privacy curtain pulled to near end of bed. There were no lights on in the	F 248	assessed to see how many times visits are needed. How the facility will monitor systems put in place: On 02/17/17, the Administrator initiated an audit tool titled In Room Visits. Audit Tool to monitor for all in room visits five times weekly for three weeks, weekly for three weeks, then monthly for three months. Any negative findings will be corrected immediately. The Dietary Manager and/or the Assistant will present findings from the Audit Tools at the monthly QI committee meetings for Three months for further recommendations. The Executive Quality Improvement Committee will review the results of the audits monthly with recommendations and follow up as needed or appropriate for continued compliance in this area. And to determine the need for and or/ frequency of continued QI monitoring.	

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F 248	Continued From page 3	F 248		

room and no music or other activity taking place. The lights were turned off in the room.

An interview was conducted with Resident #6 on 02/02/17 at 11:30 AM. During the interview Resident #6 stated that she did enjoy listening to music but due to her limited mobility she could not use the equipment to listen to music anymore. Resident #6 stated if someone would cut on the music for her she would enjoy listening to it. The resident stated that she liked Western and Church music. There was no radio or other equipment for playing music observed in the room.

On 02/02/17 an interview was conducted with Nursing Assistant (NA) #2 at 2:00 PM who cared for Resident #6. NA #2 stated Resident #6 did not go out of the room for activities and preferred to have in room activities. NA #2 stated Resident #6 had enjoyed a visit earlier in the month when a puppy was brought into the facility and visited in the room of Resident #6. NA #2 also reported that sometimes Resident #6 requested the television be cut off. NA #2 stated Resident #6 is able to make her wants known and did use the call bell when assistance was needed.

On 02/02/17 at 11:15 AM an interview was conducted by phone with the Activities Director (AD) who was out of the facility. The AD stated that the residents had an activity assessment completed when initially entering the facility, then quarterly, and whenever a readmission to the facility or a significant change in the resident's condition occurred. The AD also stated the residents who did not come into group activities have activities in their room. Those activities included crafts, reading, or having lotion put on

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F 248	Continued From page 4 hands and arms and hair combed. The Activities Director stated that at least fifteen minutes of in room visit time was required in order for the staff to record a room visit. On 02/03/17 at 8:26 AM a second interview was conducted with the AD. During the interview the AD stated there was not a list of residents who liked to listen to music, but that a CD player was available to take into resident rooms for them to use to listen to music. The AD stated that the facility had a variety of music as well as books on tape to be used with residents. Resident # 6 was known to prefer to stay in her room and she liked to listen to music. The AD stated that a record would be kept of times that a resident listened to music. There were no dates marked on the Resident's Activity Log that indicated Resident #6 had listened to music during November 2016, December 2016, or January 2017. The Activities Director also stated that the resident care plan for activities had not been updated. The care plan had intervention listen as "continue to invite resident to activities". The Activities Director stated Resident #6 had experienced a decline in the ability to attend activities over the last few months and needed in room visits and activities. The AD stated that Resident #6 was scheduled for in room activities three times per week.	F 248		
F 253 SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) 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	F 253	F 253 Housekeeping and Maintenance	2/27/17

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F 253	Continued From page 5 facility failed to label bedpans, toothbrush, and other personal care items in one bathroom (Resident room #304) on 1 of 4 resident halls and did not provide a clean environment in two rooms (Resident rooms #402 and #404) on 1 of 4 resident halls. The findings included: #1 a. Observation on 1/30/17 at 2:51 PM in the bathroom of Room #304 revealed 2 fracture bedpans in bathroom without names; one of them was dirty with tannish-white residue. The fracture bedpans were held against the wall by the grab bar and were both stored in an open plastic bag. An emesis basis was on the sink and had a name, but was not stored in a plastic bag. Other personal care items which included a bottle of Listerine mouthwash, tooth brush and tooth paste were without names and were stored in a hanging container near the sink. Two sippy cups were stored on a shelf in the bathroom without names on them and were not in plastic bag covers. b. Observation on 1/31/17 at 2:43 PM revealed in bathroom of Room #304 a tube of tooth paste and tooth brush remained in hanging container beside the sink with no name. The fracture bedpans remained hanging on wall hook in an open plastic bag and without names on them. One of the bedpans continued to have tannish-white residue on it. The two sippy cups remained on the shelf without names on them and not stored in a plastic bag. c. Observation on 2/2/17 at 8:13 AM revealed in bathroom for Room #304 that 2 fracture pans remained hanging on wall hook in open plastic	F 253	Services What measures did facility put into place for the residents affected: On 02/02/17, DON had cited rooms with items not bagged and labeled all bagged and labeled. 02/02/17 rooms cited with marks on the walls, were cleaned by housekeeping supervisor. On 02/08/17 room 402 was painted and on 02/07/17 room 404 was painted. What measures were put in place for residents having the potential to be affected: On 02/02/17 100% audit of all rooms was completed and all items were placed in bags and labeled On 02/02/17, the Maintenance Director completed a 100% audit off all rooms and a schedule was completed on rooms being cleaned and or painted. 100% in-service will be completed 02/27/17 for all housekeeping staff on making sure to notify if walls won□t come clean What systems were put into place to prevent the deficient practice from reoccurring: On 02/06/17, the Maintenance Director in-serviced 100% of housekeeping staff on deep cleaning of rooms. The in-service included walls being cleaned and notifying him if marks won□t come off walls. 02/02/17 in-service started on bagging and labeling of resident□s personal	

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F 253	Continued From page 6 bag and had no names on them. There was a toothbrush laid on the sink that did not have a name on it. The hanging container near the sink continued to have the tooth paste and mouth wash stored in it, and both items had no name on them. The two sippy cups remained on the shelf in the bathroom and did not have names on them and were stored in the open air. On 02/02/17 at 12:22 PM Nurse #3 and the Therapist Coordinator were observed as they assisted Resident #6 with the bedpan. Nurse #3 was interviewed when Resident #6 finished with the bedpan. During the interview it was acknowledged by Nurse #3 that bedpans, tooth brushes, tooth paste, and other personal care items should be labeled with the name of the resident who used them and stored in closed plastic bags. Nurse #3 also stated the sippy cups should have been stored some place other than the bathroom and the sippy cups should have been labeled with the name of the resident who used them. On 02/02/17 at 12:30 PM an interview was conducted with the DON while in the bathroom of Room #304. The DON observed the personal care items and the sippy cups stored in the bathroom without having the name of the residents on them. The DON stated it was her expectation for staff to mark items with the name of the residents who used them. #2 a. Observation on 01/31/17 at 10:38 AM of dirty wall beside the door in Room #402. The wall had some dark areas and also brown stains. The same dark marks and stains were observed again on 02/02/17 at 8:15 AM. The same dark marks and stains on the wall next to the door	F 253	belongings. All in-services will be completed on 02/27/17. How facility will monitor systems put in place: On 02/20/17, the Administrator initiated an audit tool titled labeling personal items bagged and labeled. Administrator also initiated an audit tool on walls being cleaned or painted. Audit tool to monitor five times weekly for three weeks, weekly for three weeks, then monthly times three months. Any negative findings will be corrected immediately. The Maintenance Director or designee will present findings from the Audit Tools at the monthly QI committee meetings for three months for further recommendations. The Executive Quality Improvement Committee will review the results of the audits monthly with recommendations and follow up as needed or appropriate for continued compliance in this area. And to determine the need for and or/ frequency of continued QI monitoring.	

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F 253	Continued From page 7	F 253		

were observed again on 02/02/17 at 11:20 AM.

b. Observation on 1/31/17 at 10:47 AM of dirty wall beside the door in Room #404. The wall had some dark areas and also light purple and brown stains. The same dark marks and stains were observed again on 02/02/17 at 8:15 AM. The same dark marks and stains on the wall next to the door were observed again on 02/02/17 at 11:25 AM.

A record review of the list provided by Environmental Services Manager of the inspection of rooms and repainting scheduled indicated the date each room had been repainted and floors waxed. The list indicated that Room #402 had been painted 03/01/16 and 6/14/16. The list indicated that Room #404 had been painted 02/25/16 and 06/10/16.

An interview was conducted with Housekeeper #1 on 02/02/17 at 11:15 AM. Housekeeper #1 stated that each room was to be checked to see what needed to be cleaned, including the bathroom, bed, furniture and walls. During the interview Housekeeper #1 stated the walls would be cleaned, but if an area couldn't be cleaned then the Maintenance department would paint it.

An interview was conducted with Housekeeper #2 on 02/02/17 at 11:30 AM. Housekeeper #2 stated Room #404 and Room #402 had been cleaned at the time of the interview. Housekeeper #2 stated her daily routine for cleaning included mopping floors in the bathroom, wiping down toilets with blue cleanser, and cleaning bed controls and bed rails daily. It was stated that if spills were on the wall, then they would clean it off. On 02/02/17 at 12:21 PM the stains on the walls in Room #404

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F 253	Continued From page 8 and Room #402 were pointed out to Housekeeper #2. The Housekeeper stated the stains on the walls had not been observed and had not been cleaned on 02/02/17. An interview was conducted on 02/02/17 at 12:05 PM with Environmental Services Manager (ESM) and the dark marks and stains on the walls in Rooms #404 and #402 were observed. The ESM stated his expectation was for the walls to be cleaned by housekeeping. The ESM also stated if stains could not be removed by cleaning, then the rooms would be repainted. The ESM stated the maintenance department conducted inspection of the rooms on a routine basis. On 02/02/17 at 2:45 PM the dark marks and the stains on the wall next to the door in room #402 was observed in the presence of the DON and the Administrator. The Administrator stated it was the expectation that the room be washed to remove the dark areas and stains. The DON, Administrator and Surveyor walked directly to Room # 404. The Housekeeping Supervisor was observed upon entry of Room #404 seated in the floor, using spray cleaner, and removing the stains and dark marks from the wall near the door. The Housekeeper Supervisor stated the wall could have and should have been cleaned prior to this time.	F 253		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change"	F 274		2/27/17

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F 274	Continued From page 9 means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to complete a significant change in status for 1 of 22 sampled residents (Resident #88) whose Minimum Data Set (MDS) was reviewed. Findings included: Resident #88 was admitted to the facility on 01/14/14 with diagnoses including Alzheimer's disease, high blood pressure and heart failure. Review of a quarterly MDS assessment dated 04/11/16 indicated Resident #88 required limited assistance with transfers and personal hygiene with one person physically assisting Resident #88 in each area. Review of the next quarterly MDS assessment dated 05/25/16 indicated Resident #88 required extensive assistance with transfers and personal hygiene with one person physically assisting Resident #88 in each area. Review of the most recent comprehensive assessment, a significant change in status MDS dated 10/13/16 indicated Resident #88 required extensive assistance with transfers and personal hygiene with one person physically assisting	F 274	Tag 274 Comprehensive assessment after significant change What measures did the facility put in place for the resident affected: The MDS coordinator scheduled resident #88 significant change assessment to be modified with an ARD of 2/24/17. What measures were put in place for residents having the potential to be affected: On 2/24/2017 100% of residents were audited for significant change related to any area with 2 declines since the most recent comprehensive MDS assessment by the MDS Nurse. What systems were put in place to prevent the deficient practice from reoccurring: On 2/24/2017 the MDS coordinator, MDS nurse, DON, and SDC were in-serviced by the facility consultant related to the	

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F 274	Continued From page 10 Resident #88 in each area. During an interview on 02/01/17 at 3:52 PM, the MDS Coordinator reviewed the quarterlies from 04/11/16 and 05/25/16 and verified there were 2 Activities of Daily Living (ADL) declines between the April and May MDS assessments. The MDS Coordinator further indicated he was not the Coordinator at that time, but this was an error because of the ADL declines and the assessment for 05/25/16 should have been a significant change instead of a quarterly MDS assessment. During an interview on 02/03/17 at 1:05 PM, the Director of Nursing (DON) stated her expectation was for the MDS Coordinator to know the correct assessment needed and to complete the appropriate assessment for the residents.	F 274	identification of, guidelines for, and completion of significant change in status assessment as per the RAI manual v1.13. this in-service was completed on 02/24/17. How the facility will monitor systems put in place: 2/24/2017, the DON, SDC, nurse will audit residents with declines in ADL□s using the significant change audit tool. The audit will be completed weekly x 5 weeks then monthly x 3 months. The DON and/or ADON will present findings to the monthly QI committee. The monthly QI committee will review the results of Significant Change Audit Tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate	F 278		2/27/17

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 11 each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) 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 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review and staff interviews, the facility failed to accurately assess residents ' dental status on the Minimum Data Set (MDS) assessment for 3 of 22 residents (Resident's #27, #38 and #60). Findings included: 1. Resident #27 was admitted to the facility on	F 278	FTAG 278 What measures did the facility put in place for the resident affected: 02/17/17 MDS Nurse completed dental assessments for cited residents. MDS corrected and modified MDS Assessment if applicable.	

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	345163	A. BUILDING _____ B. WING _____	C 02/03/2017

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F 278	Continued From page 12 01/23/07. The most recent comprehensive Minimum Data Set (MDS) dated 08/08/16 indicated Resident #27 had diagnoses which included non-Alzheimer's dementia and depression. The MDS also indicated Resident #27 had severely impaired cognition and required extensive assistance with eating and hygiene. The MDS further indicated Resident #27 had no dental problems. Resident #27 was observed on 02/01/17 at 5:38 PM. Resident #27 was noted to have no teeth in her upper or lower jaw. During an interview on 02/02/17 at 3:56 PM, the MDS Coordinator reviewed the comprehensive MDS assessment dated 08/08/16 and verified Resident #27 did not have teeth at that time and the dental coding was incorrect. The MDS Coordinator also stated the MDS Coordinator who incorrectly coded the dental section was no longer employed by the facility. During an interview on 02/03/17 at 1:05 PM, the Director of Nursing (DON) stated her expectation was for the MDS coding to be accurate. 2. Resident #38 was admitted to the facility on 05/31/16. The most recent comprehensive Minimum Data Set (MDS) dated 06/17/16 indicated Resident #38 had diagnoses which included dementia and difficulty swallowing. The MDS also indicated Resident #38 had moderately impaired cognition and required extensive assistance with eating and hygiene. The MDS further indicated Resident #28 had a "broken or loosely fitting full or partial denture (chipped, cracked, uncleanable or loose)." Resident #38 was observed on 02/01/17 at 9:51	F 278	What measures were put in place for residents having the potential to be affected: 02/24/17 100% audit of all residents to ensure accurate oral assessments was completed. Any inaccurate assessments will be modified if applicable. What systems were put in place to prevent the deficient practice from reoccurring: The facility MDS consultant in-serviced the MDS Coordinator, MDS nurse, and DON related to the correct coding, completing a comprehensive MDS assessment on 2/24/2017. How the facility will monitor systems put in place: On 2/24/17 the Administrator, DON and Nurse Consultant began monitoring MDS Assessments. On 2/24/17 the Nurse Consultant began monitoring each comprehensive MDS assessment to ensure proper coding. The audit will be completed 5x a week for 3 weeks then weekly x 3 weeks then monthly x 3 months. The monthly QI committee will review the results of the audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for	

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F 278	Continued From page 13 AM. Resident #38 was noted to have no teeth in her upper or lower jaw. During an interview on 02/02/17 at 8:41 AM, the Minimum Data Set (MDS) Coordinator reviewed the comprehensive MDS assessment dated 06/17/16 and verified Resident #38 did not have teeth at that time and the dental coding was incorrect. The MDS Coordinator also stated when he completed a comprehensive assessment he always asked if the resident was having any problems with their teeth and also looked in the resident's mouth. During an interview on 02/03/17 at 1:05 PM, the Director of Nursing (DON) stated her expectation was for the MDS coding to be accurate. 3. Resident #60 was admitted to the facility on 10/24/15. Review of the significant change Minimum Data Set (MDS) dated 10/31/16 revealed the MDS was coded as "none of the above" for the dental assessment. The care plan was reviewed on 01/10/16 by the facility and revealed a focus of self-care deficit. The approach was to have oral care. Staff were to rinse the dentures, clean the gums, and rinse the mouth. An observation was made on 02/02/17 at 8:37 AM of Resident #60 with dentures in place. A second observation was made on 02/03/17 at 9:03 AM of Resident #60 with no dentures or teeth in mouth. During an interview on 02/03/17 at 1:19 PM the MDS Nurse revealed the dental coding was incorrect and the MDS should have been coded	F 278	monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	

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F 278	Continued From page 14 as having no natural teeth. During an interview with the Administrator on 02/03/17 at 1:36 PM she revealed it was her expectation the MDS be coded accurately by the MDS Nurse.	F 278		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 279		2/27/17

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F 279	Continued From page 15 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop care plans for psychotropic medication use and therapeutic diet for 4 of 22 resident care plan reviews (Resident's #139, #169, #111, #38). The findings included: 1. Resident #139 was admitted to the facility on	F 279	F Tag 279 Care Planning What measures did the facility put in place for the resident affected: On 02/21/2017 residents cited are plans was updated to include resident with psychotropic medication and therapeutic diets.	

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F 279	Continued From page 16 03/19/16 with a diagnosis of Alzheimer's disease. Review of the quarterly Minimum Data Set (MDS) dated 12/23/16 revealed Resident #139 was severely cognitively impaired and received antianxiety medication during the seven day look back prior to the 12/23/16 assessment. Review of the December 2016 Medication Administration Record revealed Resident #139 received antianxiety medications. Review of Resident #139's current care plan revealed no care plan for psychotropic medication use. During an interview conducted on 02/02/17 at 4:10 PM the MDS Nurse stated it was the MDS department's responsibility to write the care plans and Resident #139 should have been care planned for psychotropic medication use. He stated it was overlooked. 2. Resident #169 was admitted to the facility on 11/04/16 with diagnoses of non-Alzheimer's dementia and anxiety. Review of the admission Minimum Data Set dated 12/21/16 revealed Resident #169 was severely cognitively impaired and received antipsychotic and antianxiety medication during the seven day look back prior to the 12/21/16 assessment . Review of the December 2016 Medication Administration Record revealed Resident #169 received antipsychotic and antianxiety medications.	F 279	What measures were put in place for residents having the potential to be affected: On 2/21/17 the Facility MDS Consultant completed a 100% audit of resident□s with psychotropic medication and therapeutic diets. All care plans were updated as necessary. What systems were put in place to prevent the deficient practice from reoccurring: On 2/24/2017 the MDS consultant in-serviced the SDC, MDS Coordinator, MDS nurse and DON related to psychotropic medication and therapeutic diets being included in resident□s plan of care. How the facility will monitor systems put in place: Resident□s with new psychotropic medications and therapeutic diets will be audited by the DON/ADON/SDC, and MDS Coordinator using the New psychotropic medication and diet Audit Tool. The audit will be completed 5x/week for 3 weeks then weekly for 3 weeks then monthly for 3 months. The monthly QI committee will review the results of the New audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for	

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F 279	Continued From page 17 Review of the care plan dated 12/28/16 revealed Resident #169 did not have a care plan for psychotropic medication use. During an interview conducted on 02/02/17 at 4:10 PM the MDS Nurse stated it was the MDS department's responsibility to write the care plans and Resident #169 should have been care planned for psychotropic medication use. He stated it was overlooked. 3. Resident #11 was admitted to the facility on 01/14/14 with diagnoses of end stage renal disease and diabetes. Review of the annual Minimum Data Set (MDS) dated 12/15/16 revealed Resident #111 was cognitively intact and received dialysis and a therapeutic diet. Review of the Care Area Assessment dated 12/18/16 revealed Resident #111 was on a no concentrated sweets renal diet. He had a medical history of type 2 diabetes, heart disease and end stage renal disease with dialysis three times a week. Proceed to care plan. Review of the care plan dated 12/29/16 revealed there was no therapeutic diet care plan for Resident #111. An interview conducted on 02/03/17 at 9:30 AM with the MDS Nurse revealed the MDS department wrote the resident care plans. He stated Resident #111 should have been care planned for a therapeutic diet. 4. Resident #38 was admitted to the facility on 05/31/16. The most recent comprehensive	F 279	monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	

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F 279	Continued From page 18 Minimum Data Set (MDS) dated 06/17/16 indicated Resident #38 had diagnoses which included dementia. The MDS also indicated Resident #38 had moderately impaired cognition and took an antipsychotic medication. The Care Area Assessment (CAA) indicated the use of an antipsychotic medication triggered for a care plan to be completed. Review of care plans indicated there was no care plan for the use of antipsychotic medication. Review of the most recent quarterly MDS assessment dated for 01/01/17 also indicated Resident #38 took an antipsychotic medication. Review of the Medication Administration Record indicated Resident #38 was being administered an antipsychotic medication. During an interview on 02/02/17 at 8:41 AM, the MDS Coordinator reviewed the care plans for Resident #38 and verified there was no care plan for the use of antipsychotic medications. The MDS Coordinator stated if a resident was on an antipsychotic medication there should always be a care plan for it. During an interview on 02/03/17 at 1:05 PM, the Director of Nursing (DON) stated her expectations were for care plans to be developed to reflect the needs of the resident and for the care plans to be updated quarterly. The DON also stated she would expect a care plan for psychotropic medications to be present as this required close monitoring.	F 279		
F 280 SS=E	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		2/27/17

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F 280	Continued From page 19 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care.	F 280		

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F 280	Continued From page 20 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 280		

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F 280	Continued From page 21 Based on medical record review and staff interview the facility failed to update the care plans for 1 of 22 residents (Resident #88) reviewed for care plan revisions. Findings included: Resident #88 was admitted to the facility on 01/14/14 with diagnoses including Alzheimer's disease, heart disease, high blood pressure, heart failure and irregular heart rhythm. The significant change in status Minimum Data Set (MDS) dated 10/13/16 indicated Resident #88 required extensive assistance with transfers, dressing, bed mobility, hygiene and toileting. Record reviews indicated a quarterly Minimum Data Set (MDS) assessment was completed on 04/11/16, 05/25/16 and 09/05/16. None of the care plans for Resident #88, with the exception of the activities care plan, were revised and updated between 04/11/16 and 09/05/16. During an interview on 02/01/17 at 3:24 PM, the MDS Coordinator stated he did not know why the care plans had not been updated and revised for Resident #88 during that time period, but acknowledged they should have been. During an interview on 02/03/17 at 8:19 AM, the Activities Director (AD) stated updates the MDS annually or when significant changes occur. The AD also stated if she noted a change in a resident she would update the care plan to reflect the change. The AD further stated she had a system of completing her assessment, activities progress note and update the care plan all in the same day.	F 280	F Tag 280 Care Planning updates What measures did the facility put in place for the resident affected: On 02/21/2017 residents cited care plans was updated. What measures were put in place for residents having the potential to be affected: On 2/24/17 the Facility MDS Nurse completed a 100% audit of resident□s care plans. All care plans were updated as necessary. What systems were put in place to prevent the deficient practice from reoccurring: On 2/24/2017 the MDS consultant in-serviced the SDC, MDS Coordinator, MDS nurse, Social Worker, Dietary Manager, and DON related to updating care plans as needed and at least quarterly. How the facility will monitor systems put in place: Resident□s care plans will be audited by the DON/ADON/SDC, and MDS Coordinator using the care plan Audit Tool. The audit will be completed 5x/week for 3 weeks then weekly for 3 weeks then monthly for 3 months. The monthly QI committee will review the results of the New audit tool monthly for 3	

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F 280	Continued From page 22 During an interview on 02/03/17 at 1:05 PM, the Director of Nursing (DON) acknowledged her expectations were for the care plans to be updated quarterly and as needed to accurately reflect the needs of each resident.	F 280	months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to … prevent complications of enteral feeding	F 328		2/27/17

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F 328	Continued From page 23 including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to administer oxygen at the physician ordered liters per minute for 1 of 6 residents reviewed for oxygen therapy (Resident #141). The findings included: Resident #141 was admitted to the facility on	F 328	F TAG 328 What measures did the facility put in place for the resident affected: 02/02/17 Hospice was called to assess resident on 02 administration, and new orders was obtained. What measures were put in place for	

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F 328	Continued From page 24 06/11/16 with diagnoses of high blood pressure and cerebral vascular accident. Review of the quarterly Minimum Data Set dated 10/30/16 revealed Resident #141 was cognitively intact and used oxygen. Review of Resident #141's Physician order's for February 2017 revealed an order initiated on 06/11/16 for oxygen at 2 liters per minute via nasal cannula as needed. Observations of Resident #141 throughout the survey revealed the following: "02/01/17 at 10:08 AM Resident #141 lying in bed with oxygen in use via nasal cannula with the flow meter on the oxygen concentrator set at 3.5 liters per minute. "02/01/17 at 4:29 PM Resident #141 lying in bed with oxygen in use via nasal cannula with the flow meter on the oxygen concentrator set at 3.5 liters per minute. "02/02/17 at 8:53 AM Resident #141 lying in bed with oxygen in use via nasal cannula with the flow meter on the oxygen concentrator set at 3.5 liters per minute. "02/02/17 at 2:52 PM Resident #141 lying in bed with oxygen in use via nasal cannula with the flow meter on the oxygen concentrator set at 3.5 liters per minute. An interview conducted on 02/01/17 at 4:32 PM with Resident #141 revealed he would take his oxygen on and off when he wanted to. He stated he would turn the oxygen concentrator on and off as well and he did not know what the flow rate was set at.	F 328	residents having the potential to be affected: 02/24/17 100% audit of all residents to ensure accurate o2 administration, 100% in service on all nursing staff related to monitor and report to nurse when o2 has been taken off by resident. What systems were put in place to prevent the deficient practice from reoccurring: The facility began on 2/1/17 in service by DON/ ADON to all nursing staff related to monitor and reporting to nurse when residents have taken off o2, so that nurse can obtain o2 stat before replacing o2. How the facility will monitor systems put in place: On 2/24/17 the DON, ADON, SDC or Designee will monitor residents on o2 to make sure orders are being followed. The DON, ADON, SDC or Designee will audit using the o2 audit tool. The audit will be completed 5x a week for 3 weeks then weekly x 3 weeks then monthly x 3 months. The monthly QI committee will review the results of the audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the	

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F 328	Continued From page 25 An interview conducted on 02/02/17 at 3:02 PM with Nurse #4 revealed Resident #141 would take his oxygen on and off and turn his oxygen concentrator on and off. He stated it was his responsibility to check the flow rate of Resident #141's oxygen and he had not checked the oxygen concentrator to see what the flow meter was set at. An interview conducted on 02/02/17 at 3:00 PM with the Restorative Nurse Aide #2 revealed she had just worked with Resident #141 and took him back to his room and unconnected his oxygen tubing from the portable oxygen tank and reconnected it to the oxygen concentrator in his room. She stated the oxygen concentrator was already on when she connected the oxygen tubing to it and she did not check to see what the flow meter was set at. During an interview on 02/02/17 at 3:05 PM the Director of Nursing stated it was her expectation for Resident #141's oxygen to be set at the physician ordered rate and for the staff to make sure it was at the correct rate when in use.	F 328	monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	
F 369 SS=D	483.60(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS (g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, and staff	F 369	FTAG 369 ADAPATIVE EQUIPMENT	2/27/17

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F 369	Continued From page 26 interviews, the facility failed to provide adaptive eating equipment for 1 of 1 (Resident #21) sampled resident during 1 of 2 meal observations. Findings included: Resident #20 was admitted to the facility on 04/01/15 with diagnoses of cerebrovascular accident and hemiparesis. A review of the quarterly Minimum Data Set (MDS) dated 01/07/17 revealed there was severe impaired cognition with extensive assistance for activities of daily living and limited assistance with meals. The care plan dated 04/28/15 for Resident #20 was reviewed with a focus to assist with activities of daily living, and risk of dehydration. The interventions were to encourage resident participation in self-care, provide assistance with eating, and physical and occupational therapy as indicated. The goals were to remain free from signs and symptoms of dehydration, and to maintain the highest level of functioning. An occupational therapy discharge summary dated 08/16/16 thru 10/03/16 was reviewed. Resident #20 was to safely perform self-feeding task with set-up and use of a nosey cup (a cup with a cut out for the nose) to increase self-feeding, increase nutritional status, and decrease risk of dehydration. An observation on 01/31/17 at 11:17 AM was done of the lunch service in the restorative dining room. The Restorative Aide (RA) #1 was feeding Resident #20 lunch. The meal was served on a divided plate. There was no nosey cup or curved left handle spoon used for the entire meal. The	F 369	What measures did the facility put in place for the resident affected: On 02/13/17 resident was revaluated by speech therapy for need of assistive device during meals. On 02/13/17 dietary manager notified of recommendation to ensure device will be placed on resident tray card for all meals. On 02/13/17 100 % audit of all residents was completed to identify resident with recommendation for assistive devices. What measures were put in place for residents having the potential to be affected: On 02/13/17 100 % audit of all residents was completed to identify residents with recommendations for assistive devices was completed by Rehab Manager and Dietary Manager with corrections made as necessary on 02/13/17 the dietary manager audited 100% of resident tray cards to ensure correct assistive device was listed and updating tray cards as necessary. What systems were put in place to prevent the deficient practice from reoccurring: ON 02/13/17 the administrator in-serviced the dietary manager related to assistive devices being listed on the tray cards and being sent out with each meal. The dietary manager began in-servicing the dietary	

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F 369	Continued From page 27 RA #1 would encourage to feed self, but there were no attempts made by Resident #20 during the observation of lunch. A review of the meal ticket on 01/31/17, revealed the adaptive equipment used for Resident #20 was a divided plate, nosey cup, and left handled curved spoon. An interview with the RA #1 on 02/01/17 at 11:05 AM, confirmed Resident #20 did not have a nosey cup or the left angled spoon for the lunch meal on 01/31/17. RA #1 confirmed the adaptive equipment was not always used. RA #1 explained, if Resident #20 hands shake less he does better without the equipment. An interview with the Rehabilitation Director on 02/01/17 at 12:00 PM, revealed therapy would meet with the kitchen manager when new recommendations for adaptive equipment was needed for a resident. It was her expectation for the adaptive equipment to be on the tray when sent to the dining room. It was her expectation for the Restorative Aides to inform therapy if the adaptive equipment was not made available, or when a problem was identified. An observation of the restorative dining room meal service on 02/02/17 at 11:13 AM, revealed Resident #20 had a nosey cup, a left curved spoon with a built up handle, and a divided plate. Resident #20 was able to feed himself using the adaptive equipment. An interview with the Dietary Manager (DM) on 02/03/17 at 9:48 AM was conducted. The DM confirmed therapy brings the equipment they want the resident to use. She confirmed Resident	F 369	department on assistive devices being on the tray card and placing device on resident tray card for each meal. On 02/13/2017 began in-servicing 100% of nursing staff related to reading resident tray card to check for the need of assistive devices, ensuring the is on the tray card and offering the device for the resident to use. On 02/22/17, the Administrator initiated an audit tool titled Adaptive Equipment. Audit tool will be done five times weekly for three weeks, weekly for three weeks, then monthly for three months. Any negative findings will be corrected immediately. The Dietary Manager and/or the Assistant will present findings from the Audit Tools at the monthly QI committee meetings for Three months for further recommendations. How the facility will monitor systems put in place: The monthly QI committee will review the results of the tray card Audit monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	

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F 369	Continued From page 28 #20 used adaptive equipment and the equipment should be sent with the food tray. She provided a copy of the meal ticket for Resident #20. The ticket confirmed the adaptive equipment for Resident #20 was a divided plate, nosey cup, and left handle curved spoon. During an interview with Administrator on 02/03/17 at 1:30 PM, she revealed it was her expectation for the RA to communicate with therapy any changes identified when using special eating adaptive equipment. It was her expectation for the RA to ensure the adaptive equipment was available and to inform therapy when it was not available.	F 369		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments;	F 514		2/27/17

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F 514	Continued From page 29 (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review, and staff interview the facility failed to 1) document the administration of an antipsychotic medication and 2) document the effectiveness of an antianxiety medication administered for 1 of 5 residents reviewed for unnecessary medications (Resident #38) and 3) document the effectiveness of an antidepressant and antipsychotic medication administered for 1 of 5 residents (Resident #102). Findings included: Resident #38 was admitted to the facility on 05/31/16. The most recent comprehensive Minimum Data Set (MDS) dated 06/17/16 indicated Resident #38 had diagnoses which included dementia and difficulty swallowing. The MDS also indicated Resident #38 had moderately impaired cognition and required limited to extensive assistance with most Activities of Daily Living (ADL's). The MDS further indicated Resident #38 had been given an antipsychotic medication.	F 514	F Tag 514 PRN Pain Medication Effectiveness What measures did the facility put in place for the resident affected: On 02/13/17 pain assessment completed for all cited residents by License Nursing Staff. Cited residents reporting PRN medication is effective. What measures were put in place for residents having the potential to be affected: A pain assessment was completed on 100% of residents by a RN. All assessments were completed by 2/23/2017. No negative findings were identified. What systems were put in place to prevent the deficient practice from reoccurring:	

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F 514	Continued From page 30 1. Review of physician's orders indicated an order was present as of 01/17/17 for an antipsychotic medication to be given on a rotating dosage schedule at night (alternating 12.5mg with 25mg). Review of the Medication Administration Record (MAR) for January 2017 indicated the medication was not documented as given on 3 occasions during a two week period (from 01/17/17 to 01/31/17). The dates there was no documentation included January 19th, 22nd, and 31st at 9:00 PM. Review of the staffing schedule for these dates indicated the same nurse worked these evenings. During an interview on 02/02/17 at 9:22 AM, Nurse #2 (N #2) indicated she had worked these evenings. When questioned about the medications, N #2 indicated she was sure she had administered the medication but must have forgotten to document it. N #2 also stated "I try to go back and make sure I've signed out everything. I must have missed them or thought I had signed them." During an interview on 02/03/17 at 1:05 PM, the Director of Nursing (DON) stated her expectations were for medications to be signed off on the MAR when they are given. The DON also indicated if a resident refused a medication, the nurse was to attempt to offer the medications 3 times, and if the medication was still refused the nurse should circle the area on the MAR and notify the doctor. The DON further indicated when a documentation error was discovered, an attempt was made to contact the nurse	F 514	On 02/24/17 the facility consultant, director of nursing (DON), and staff development coordinator(SDC) started an in-service with 100% of licensed staff related to the importance of documentation of PRN pain medications to include the medication given, the reason, the time given, the reason, the route, and the effectiveness. In-servicing will be completed 2/27/17. All newly hired licensed staff employees will receive in-service with new employee orientation. How the facility will monitor systems put in place: Beginning 2/13/2017, the DON, assistant director of nursing (ADON), SDC, and/or QI nurse will audit documentation of effectiveness of prn medication given using the Documentation of Effectiveness of PRN Medication Audit Tool. The audit will be completed 5x/week for 3 weeks then weekly for 3 weeks then monthly for 3 months. The DON and/or ADON will present findings to the monthly QI committee. The monthly QI committee will review the results of the Documentation of Effectiveness of PRN Medications Audit Tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and	

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F 514	Continued From page 31 responsible as the nurse only has 24 hours to sign off that the medication was given. 2. Review of physician's orders indicated an order was present for an antianxiety medication to be given as needed every 8 hours for anxiety or sleep. Review of the Medication Administration Record (MAR) for January 2017 indicated the medication was given on 01/26/17 and 01/29/17 but no results were documented for the effectiveness for the medication given on 01/29/17. During an interview on 02/02/17 at 9:18 AM, the Medication Aide (MA) stated she was working the night of 01/29/17. The MA also indicated Resident #38 was very restless that evening and she had asked Nurse #2 (N #2) to assess her before giving her an antianxiety medication. The MA further indicated she gave the antianxiety medication to Resident #38 and saw her about 30 minutes later and she appeared to be sleeping and slept good throughout the rest of the night. During an interview 02/02/17 at 9:22 AM, Nurse #2 (N #2) indicated she was working the evening of 01/29/17. N #2 stated Resident #38 had a history of calling out at night and screaming. N #2 also stated the MA had asked her to assess Resident #38 and after she did so the MA gave Resident #38 an antianxiety medication. N #2 stated that she went back in Resident #38's room about 30 minutes later and saw that she was sleeping. N #2 further indicated she tried to remember to document on the back of the MAR about effectiveness of as needed antianxiety medications, but she must have forgotten to do so with this medication.	F 514	recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	

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F 514	Continued From page 32	F 514		

During an interview on 02/03/17 at 1:05 PM, the Director of Nursing (DON) stated her expectations were for a resident to be assessed first to see if a resident can be calmed before an as needed antianxiety medication is given. The DON also stated if the antianxiety medication is given, she expected the nurse to reassess the situation and document whether or not the medication was effective.

3. Resident #102 was readmitted to the facility on 12/27/16 with the diagnoses of depression and anxiety disorder. Review of the admission Minimum Data Set dated 01/04/17 revealed Resident #102 was cognitively intact with extensive assist for activities of daily living.

Review of the care plan dated 12/20/16, revealed a focus of frequent behavior problems with the approach to administer medications as ordered and monitor and document for effectiveness.

A review the physician orders for December, 2016 and January, 2017, revealed haloperidol (medication used for mental health behaviors) take one tablet by mouth every 8 hours as needed agitation. Trazodone (medication used for depression) take one tablet by mouth nightly at bedtime as needed for sleep.

A review of the Medication Administration Record (MAR) for December 2016 revealed haloperidol was administered on 12/28/16, 12/29/16, and 12/31/16. There was no documentation if the

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F 514	Continued From page 33 medication was effective. The MAR for January 2017 revealed trazodone was administered on 01/26/17 and 01/31/17. There was no documentation if the medication was effective. The MAR for January, 2017 revealed haloperidol was administered on 01/31/17. There was no documentation if the medication was effective. During an interview with Nurse #2 on 02/03/17 at 10:08 AM, she revealed Resident #102 had behaviors of hollering and worried about missing a train. With extreme agitation the resident could have haloperidol. She confirmed haloperidol was administered on 01/31/16 at 3:00 PM, but forgot to document the effectiveness. She confirmed being trained to document if as needed medications are effective on the MAR. During an interview with the Administrator on 02/03/17 at 1:36 PM, she revealed it was her expectation the nurse administering as needed medications document the effectiveness of the medication.	F 514		
F 520 SS=E	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's	F 520		2/27/17

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F 520	Continued From page 34 staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review, resident and staff interviews the facility ' s Quality Assurance Committee (QAC) failed to maintain implemented procedure and monitor those procedures put into place in January of 2016. This was for 2 recited deficiencies originally cited in December of 2015. The deficiencies were in the areas of assessment accuracy and developing comprehensive care plans. The continued failure of the facility during 2 federal	F 520	F 520 QAA Committee On 2/14/17 the facility Executive QI Committee held a meeting. Administrator, DON, MDS Nurse, Treatment nurse, Staff facilitator, Maintenance Director, and Housekeeping Supervisor will attend QI Committee Meetings on an ongoing basis and will assign additional team members as appropriate.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 35 surveys of record show a pattern of the facility ' s inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referenced to: F 278 Assessment Accuracy - Based on observations, medical record review and staff interviews the facility failed to accurately assess residents ' dental status on the Minimum Data Set (MDS) for 3 of 22 residents (Resident ' s #27, #38, and #60). F 279 Developing Comprehensive Care Plans - Based on medical record review and staff interviews the facility failed to develop care plans for psychoactive medication use for 4 of 22 care plan reviews (Resident ' s #139, #169, #111 and #38). During an interview on 02/03/17 at 2:05 PM the Administrator stated the QAC met monthly and plans were to continue this process but at the minimum to meet at least every quarter. The Administrator verified they identified issues, put a plan into action and observed trends to determine if the plan was successful or needed to be modified. The Administrator further stated the administrative staff was trying to identify operational and system issues in each department. This process started as an internal audit of each department and resulted into a lot of education for the staff by in-services where they were actually shown what needed to be done and were not just signing off on a piece of paper stating they had attended an in-service. The Administrator also stated there were numerous	F 520	On 2/14/17 the facility consultant in-serviced the facility administrator, director of nursing, MDS nurse, treatment nurse, maintenance director, dietary manager, and housekeeping supervisor related to the appropriate functioning of the QI Committee and the purpose of the committee to include identify issues related to quality assessment and assurance activities as needed and developing and implementing appropriate plans of action for identified facility concerns. As of 2/14/17, after the facility consultant in-service, the facility QI Committee will begin identifying other areas of quality concern through the QI review process, for example: review rounds tools, review of work orders, review of Point Click Care (Electronic Medical Record), resident council minutes, resident concern logs, pharmacy reports, and regional facility consultant recommendations. The Facility QI Committee will meet at a minimum of Quarterly to identify issues related to quality assessment and assurance activities as needed and will develop and implementing appropriate plans of action for identified facility concerns. The Committee will continue to meet at a minimum of monthly. The Executive QI Committee, including the Medical Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345163	A. BUILDING _____ B. WING _____	C 02/03/2017

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F 520	Continued From page 36 areas currently under review of the QAC for improvement.	F 520	will meet on a quarterly basis, the committee will review monthly compiled QI report information, review trends, and review corrective actions taken and the dates of completion. The Executive QI Committee will validate the facility□s progress in correction of deficient practices or identify concerns. The administrator will be responsible for ensuring Committee concerns are addressed through further training or other interventions. The administrator or her designee will report back to the Executive QI Committee at the next scheduled meeting.	