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	345216	A. BUILDING _____ B. WING _____	02/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTFIELD REHABILITATION AND HEALTH CENTER	3100 TRAMWAY ROAD SANFORD, NC 27332

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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 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 staff interviews and record review, the facility failed to accurately code a comprehensive	F 278	The statements made on this Plan of Correction are not an admission to and do	3/17/17

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

Electronically Signed | 03/17/2017

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F 278	Continued From page 1 Minimum Data Set (MDS) assessment for a Preadmission Screening Resident Review (PASRR) for 1 of (Resident # 22) 1sampled resident reviewed for PASRR. The facility also failed to accurately code a quarterly MDS assessment for diagnoses for 1 of (Resident #105) 5 sampled residents reviewed for unnecessary medications. Findings included: 1. Resident #22 was admitted on 9/22/10 with cumulative diagnoses of cerebral vascular accident (CVA), dementia, anxiety and depression. On the annual MDS dated 1/15/17, Section A 1500 was coded for a level II PASRR but there was no condition checked to justify Level II PASRR for Resident #22. The facility provided a letter dated 1/8/17 which read there was no expiration date for Resident #22 ' s level II PASRR. In an interview on 2/21/17 at 4:50 PM, the social worker (SW) stated she verified the Level II PASRR but she did not know the associated mental condition. She stated the MDS nurse coded section A of the MDS assessment. In an interview on 2/23/17 at 10:15 AM, MDS Nurse #1 stated the annual assessment dated 1/15/17 section A should have indicated the condition present for Resident #22 ' s level II PASRR. She stated it was an oversight. In an interview on 2/23/16 at 12:15 PM, the Director of Nursing stated it was her expectation the MDS be coded completely and accurately. 2. Resident #105 was admitted to the facility on	F 278	not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F278 Corrective Action for Resident Affected On 2/23/17, the following MDS Assessments that were in the surveyor sample list were corrected via modifications to reflect accurate resident issues that had been inaccurately coded on the MDS Assessments. Those in the resident sample included; Resident # 22 the PASRR level II coding in section A1500 for associated mental condition. Resident # 105 for active diagnoses of Depression and Seizure disorder due to use of the medications; Lexapro, Effexor and Keppra. These MDS assessments modifications were completed by the MDS Coordinator on 2/23/17 and submitted to CMS. Corrective Action for Resident Potentially Affected All residents have the potential to be affected by this practice. On 03/17/17, the	

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F 278	Continued From page 2 9/24/15 with multiple diagnoses including Depression and Seizure Disorder. The quarterly Minimum Data Set (MDS) assessment dated 12/27/16 did not indicate that Resident #105 had diagnoses of Depression and Seizure Disorder. Resident #105's February 2017 physician's orders were reviewed. The orders revealed that Resident #105 was on Lexapro and Effexor for Depression and Keppra for Seizure Disorder. On 2/22/17 at 4:55 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS assessments to be accurate. On 2/23/17 at 10:15 AM, the MDS Nurse was interviewed. The MDS Nurse reviewed the resident's electronic medical records and indicated that she missed coding the diagnoses of Depression and Seizure Disorder on the 12/27/16 quarterly MDS assessment.	F 278	corporate MDS consultant provided education to the MDS nurses on coding the MDS accurately per the RAI instructions all residents with a level II PASRR must also be coded for an associated mental condition and if none of the listed ones applied, they would select other as the option. They would code all active diagnoses including all those that the resident was being medicated for. The MDS nurses reviewed the most recent OBRA MDS assessments for accurate coding. Any MDS assessments that missing active diagnoses were corrected via modifications by 3/17/17. Systemic Changes On 3/13/17, the MDS nurses were both provided with re-education on accurate MDS coding. This education was provided by the MDS Consultant. The in service included; coding level II PASRR on the MDS accurately with the associated mental conditions and also coding residents□ active diagnoses including the medications that the residents□ are currently taking. The medications the resident takes should be affiliated to their active diagnoses. Any inactive diagnoses should be resolved on the resident□s clinical record and all active diagnoses coded as such on their clinical record to ensure accurate MDS coding which should be maintained at all times. This information has been integrated into the routine in service(s) for RN MDS	

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F 278	Continued From page 3	F 278	Coordinator / MDS support nurse and in the required in-service refresher courses and will be reviewed by the Quality Assurance Process to verify that the change is maintained. Quality Assurance The facility Director of Nursing will audit up to two residents MDS comprehensive assessments for accuracy of the various identified areas. This will be done weekly for one month then monthly for three months or until resolved by Quality Assurance Committee. Reports will be presented to the weekly QA committee by the Administrator or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the monthly QA Meeting. The monthly QA Meeting is attended by the DON, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator. Compliance date: 3/17/17	
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.	F 279		3/17/17

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F 279	Continued From page 4	F 279		

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 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.

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F 279	Continued From page 5 (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 staff interviews and record review, the facility failed to care plan a resident for a significant weight loss for 1 of (Resident #111) 3 residents reviewed for nutrition. Findings included: Resident #111 was admitted 3/24/16. Her weight on admission (3/24/16) was 139.2 pounds with her ideal body weight between 135 and 164 pounds according to her dietary review on admission. A review of Resident #111 ' s weights were as follows: 9/1/16 130.8 pounds 10/27/16 125 pounds 11/7/16 126.2 pounds 12/1/16 110.6 pounds The quarterly Minimum Data Set (MDS) dated 12/15/16 indicated her cognitive status was not assessed and she required extensive assistance with eating. Resident #111 was also coded for a weight loss.	F 279	F 279 Corrective Action for Resident Affected On 2/22/17, the care plan for resident #111 on the surveyor sample list was updated by the MDS nurse to reflect a focus for significant weight loss. On 3/14/17, the Dietary Manager at the facility was educated on creating care plans and updating care plans as appropriate so as to reflect the resident□s nutritional status as triggered on the MDS, any significant weight change (loss / gain). Identification of other residents who may be involved with this practice: All residents have the potential to be affected by this practice. On 3/10/17, the corporate Registered Dietitian initiated a chart audit for all current residents who had a significant weight change (loss / gain in the past 30, 90 and / or 180 days) to ensure that weight loss was identified,	

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F 279	Continued From page 6 1/1/17 124 pounds Resident #111 was readmitted on 1/20/17 with cumulative diagnoses of cerebral vascular accident (CVA), seizures, hemiplegia and dysphagia. 1/20/17 125 pounds 1/25/17 111 pounds 1/30/17 110.8 pounds 2/1/17 119.4 pounds 2/15/17 110.6 pounds 2/22/17 107.6 pounds A review of a dietician note dated 1/29/17 read Resident #111 had significant weight loss since her admission with a body mass index of 19.7. A nutritional supplement was recommended twice daily. A review of the care plan last revised on 2/7/17 did not include a focus for significant weight loss. In a telephone interview on 2/22/17 at 2:50 PM, the facility registered dietician (RD) stated the MDS nurse was care planning the weight loss since she was only at the facility once weekly. In an interview on at 10:15 AM, MDS Nurse #1 stated the dietician was responsible for care planning significant weight loss for Resident #111. In an interview on 2/23/16 at 12:15 PM, the Director of Nursing stated it was her expectation the significant weight loss would have been addressed in Resident #111 ' s care plan.	F 279	dietary interventions were in place and that care plans were updated. These were 18 who had significant weight change (gain / loss). 14 residents were found with no care plans addressing the significant weight change. The medical Director was notified, resident representative□s notified, Dietitian was notified, and interventions were implemented, and care plans were revised and updated with a new focus addressing the significant weight change. Systemic Changes On 3/14/17 the facility Dietary Service Director was in-serviced on creating care plans with new focus on significant weight change (loss / gain), updating dietary care plans upon identification of any change so that the care plans accurately reflects the resident and that this is maintained at all times. This information has been integrated into the routine in service(s) the Dietary Service Director and in the required in-service refresher courses and will be reviewed by the Quality Assurance Process to verify that the accuracy is maintained. Monitoring To ensure compliance, Director of Nursing or Unit Manager will monitor this issue using the QA survey tool. The facility will monitor compliance by reviewing 5 residents□ with significant weight loss and review their comprehensive person centered care plan to ensure that it is developed and implemented for each	

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F 279	Continued From page 7	F 279	resident, consistent with the resident□s right that includes measurable objectives and timetables to meet a resident□s medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. This will be done on weekly basis for 4 weeks then monthly for 3 months by the Director of Nursing, Support Nurse, Unit Manager, or designee. Reports will be presented to the weekly QA Committee by the Administrator or designee to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Social Services. Compliance date: 3/17/2017	
F 280 SS=E	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 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.	F 280		3/17/17

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F 280	Continued From page 8 (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. 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--	F 280		

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F 280	Continued From page 9 (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: Based on record review, resident interview, and staff interview, the facility failed to include the resident and/or responsible party (RP) in the care planning process for 5 of 5 sampled residents (Residents #22, #33, #73, #82, and #109). The findings included: 1. Resident #109 was admitted to the facility on 2/26/16 with multiple diagnoses that included dysarthria (motor speech disorder) following a	F 280	F 280 RIGHT TO PARTICIPATE PLANNING CARE REVISE Care Plan Corrective Action: Facility has notified Residents; # 22, #33, # 82, #73 and # 109 representatives of care plan conferences on 2/21/2017 and have scheduled care plan conferences that were held on 3/9/2017, 3/7/2017, 3/9/2017 and 3/7/2017and 3/9/17 respectively. All care plan conferences	

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F 280	Continued From page 10 cerebral infarction (stroke). The quarterly Minimum Data Set (MDS) dated 11/20/16 indicated Resident #109 had moderate cognitive impairment. An interview was conducted with Resident #109 on 2/20/17 at 4:01 PM. He indicated he was not involved in the care planning process. A review of the medical record indicated Resident #109 was his own RP. A review of the electronic medical record and the hard copy medical record revealed no care plan meetings were held for Resident #109 since his admission to the facility (2/26/16). An interview was conducted with the Social Worker (SW) on 2/21/17 at 3:50 PM. She indicated the facility utilized care plan meetings to involve the resident and/or RP in the care planning process. She reported she was responsible for scheduling the meetings and for inviting residents and RPs. She indicated the MDS nurse provided her with a list of MDS assessments with upcoming due dates and she utilized that list to keep track of when care plan meetings were due to be scheduled. The SW reported she mailed care plan meeting invitations to the RPs and informed the residents verbally. She indicated the documentation process had been revamped in November or December of 2016 to utilize electronic medical record documentation of the care plan meetings. She reported that prior to that time the care plan meetings were documented in the hard copy medical record.	F 280	were held with the facility interdisciplinary team members and with resident and /or resident representatives on the respective dates. Identification of other residents who may be involved with this practice: The MDS nurses and the Social Services Director reviewed all the 33 long- term care residents at the facility and found 5 of the residents and their responsible parties had not been notified about care plan conferences. The facility notified the residents and their responsible parties of care plan conferences and scheduled care plan conferences that were held on 3/7/17 and 3/9/17 respectively. Systemic Changes: In-service was provided for the interdisciplinary Team which include MDS Coordinators, Social Service , Dietary , Therapy and Activities on the residents right (unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State) to participate in planning care and treatment or changes in care and treatment on 3/16/2017. Topics included; resident and their responsible party to care plan conference, completing a comprehensive care plan within 7 days after the completion of a comprehensive assessment prepared by an interdisciplinary team and the importance of including the attending physician , a registered nurse with responsibility for the resident and other appropriate staff in disciplines as determined by the resident□s needs and to the extent practicable , the participation of the resident, the resident□s family or the	

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F 280	Continued From page 11 The interview with the SW continued. The electronic medical record and hard copy medical record for Resident #109 that indicated he had no care plan meetings held since his admission to the facility (2/26/16) was reviewed with the SW. She confirmed there was no documentation in the medical record of Resident #109 having had a care plan meeting. She revealed this one must have been missed. She reported she was going to contact Resident #109 to schedule a care plan meeting. An interview was conducted with the Director of Nursing (DON) on 2/22/17 at 4:51 PM. She indicated the facility utilized care plan meetings to involve the resident and/or RP in the care planning process. She reported her expectation was for a care plan meeting to be held at least once every quarter for each resident. 2. Resident #82 was admitted to the facility on 11/13/13 and readmitted on 11/27/13 with multiple diagnoses that included hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one side of the body) following cerebral infarction (stroke). The quarterly MDS dated 2/2/17 indicated Resident #82 had short term memory problems, long term memory problems, and he was rarely/never understood. A review of the electronic medical record and the hard copy medical record revealed no care plan meetings were held for Resident #82 within the last year. An interview was conducted with the SW on	F 280	resident□s legal representative ; and periodically reviewed and revised by a team of qualified persons after each assessment. Any interdisciplinary staff member or any in-house staff involved with the participation or completion of comprehensive care plans, who did not receive in-service training, will not be allowed to work or participate in completing a comprehensive care plan for residents until training has been completed. Monitoring: Using the QA Survey Tool the MDS Coordinator will check five residents that have Comprehensive care plans completed within 7days after the completion of a comprehensive assessment and ensure that the residents and or residents□ responsible parties have been notified of care plan conferences and have a care plan conference scheduled. This will be done five times a week for four weeks then monthly for two months. Identified issues will be reported immediately to DON or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the DON, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manage, the Administrator, Social service and other members as needed. Date of Compliance 3/17/2017	

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2/21/17 at 3:50 PM. She indicated the facility utilized care plan meetings to involve the resident and/or RP in the care planning process. She reported she was responsible for scheduling the meetings and for inviting residents and RPs. She indicated the MDS nurse provided her with a list of MDS assessments with upcoming due dates and she utilized that list to keep track of when care plan meetings were due to be scheduled. The SW reported she mailed care plan meeting invitations to the RPs and informed the residents verbally. She indicated the documentation process had been revamped in November or December of 2016 to utilize electronic medical record documentation of the care plan meetings. She reported that prior to that time the care plan meetings were documented in the hard copy medical record.

The interview with the SW continued. The electronic medical record and hard copy medical record for Resident #82 that indicated he had no care plan meetings held in the past year was reviewed with the SW. She confirmed there was no documentation in the medical record of Resident #82 having had a care plan meeting. She revealed this one must have been missed. She reported she was going to contact Resident #82 and his RP to schedule a care plan meeting.

An interview was conducted with the DON on 2/22/17 at 4:51 PM. She indicated the facility utilized care plan meetings to involve the resident and/or RP in the care planning process. She reported her expectation was for a meeting to be held at least once every quarter for each resident.

3. Resident #33 was admitted on 12/1/15 with

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cumulative diagnoses of benign prostate hypertrophy (BPH), urinary retention and chronic obstructive pulmonary disease (COPD).

The annual Minimum Data Set (MDS) dated 11/25/16 indicated he was cognitively intact and was coded for extensive assistance with his activities of daily living (ADLs).

A review of Resident #33 ' s paper and electronic record included no care plan conference notes since 5/18/16.

In an interview on 2/21/17 at 3:50 PM, the social worker (SW) stated the facility utilized care plan conferences to involve residents and the responsible party (RP) in the care planning process. The SW verified she was responsible for scheduling the care plan conferences. She stated the MDS nurse provided her with a list of MDS assessments that were due for completion and she tried to schedule the care plan conferences in correlation with that schedule. The SW reported she mailed letters to the RP if applicable and/or informed residents were deemed cognitively intact of the scheduled conference time. She stated she began working at the facility in June 2016 and there had been multiple changes in the MDS department. During the MDS staff transition, the care planning process was not followed and she was working to get the care planning process back on schedule.

In an interview on 2/23/17 at 10:15 AM, MDS nurse #1 stated she gave the SW a copy of the upcoming MDS assessments and the SW was responsible for scheduling the care plan conferences and invited the resident ' s. RP or the resident if they were cognitively intact. MDS nurse

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F 280	Continued From page 14 #1 stated every resident should have a care plan conference quarterly. In an interview on 2/23/16 at 12:15 PM, the Director of Nursing stated it was her expectation the care plan conferences be scheduled quarterly and the RP and/or the resident be invited. 4. Resident #22 was admitted on 9/22/10 with cumulative diagnoses of cerebral vascular accident (CVA), dementia, anxiety and depression. The annual MDS dated 1/15/17 indicated Resident #22 was cognitively intact and coded for extensive assistance with his ADLs. A review of Resident #22 ' s paper and electronic record included no care plan conference notes in the past year. In an interview on 2/21/17 at 3:50 PM, the SW stated the facility utilized care plan conferences to involve residents and the responsible party (RP) in the care planning process. The SW verified she was responsible for scheduling the care plan conferences. She stated the MDS nurse provided her with a list of MDS assessments that were due for completion and she tried to schedule the care plan conferences in correlation with that schedule. The SW reported she mailed letters to the RP if applicable and/or informed residents were deemed cognitively intact of the scheduled conference time. She stated she began working at the facility in June 2016 and there had been multiple changes in the MDS department. During the MDS staff transition, the care planning process was not followed and she was working to get the care planning process back on schedule.	F 280		

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In an interview on 2/23/17 at 10:15 AM, MDS nurse #1 stated she gave the SW a copy of the upcoming MDS assessments and the SW was responsible for scheduling the care plan conferences and invited the residents RP or the resident if they were cognitively intact. MDS nurse #1 stated every resident should have a care plan conference quarterly.

In an interview on 2/23/16 at 12:15 PM, the Director of Nursing stated it was her expectation the care plan conferences be scheduled quarterly and the RP and/or the resident be invited.

5. Resident #73 was admitted to the facility on 11/6/15 with multiple diagnoses including Hypertension. The quarterly Minimum Data Set (MDS) assessment dated 11/11/16 indicated that Resident #73's cognition was intact.

On 2/20/17 at 11:35 AM, Resident #73 was interviewed. She stated that she did not feel included in the decision about her medications, therapy or other treatments.

On 2/21/17 at 3:20 PM, Resident #73 was again interviewed. She stated that she had been at the facility for more than a year and nobody had invited her to any care plan conference.

The medical records including electronic records of Resident #73 were reviewed. There were no documentation that Resident #73 was involved in the care planning process.

On 2/21/17 at 3:43 PM, the Social Worker (SW) was interviewed. She stated that she was responsible for inviting residents and or the

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F 280	Continued From page 16 Responsible Party (RP) to the care plan conference. She further indicated that if the resident and or the RP were invited to the care plan conference, the documentation could be found under the social service progress notes. After reviewing the resident's medical records, the SW stated that she could not find documentation that the resident or the RP were invited to participate in the care planning process. On 2/22/17 at 4:40 PM, the Director of Nursing (DON) was interviewed. The DON stated that her expectation was to involve the alert and oriented residents in the care planning process. On 2/23/17 at 10:15 AM, the MDS Nurse was interviewed. The MDS Nurse stated that the SW was responsible for inviting the residents and the RP to the care plan conference and to document their involvement in the resident's medical records.	F 280		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to follow care planned interventions for 1 (Resident #33) of 2 residents reviewed for urinary catheters. Findings included:	F 282	F 282 Corrective Action for Resident Affected	3/17/17

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F 282	Continued From page 17 Resident #33 was admitted 12/1/15 with cumulative diagnoses of benign prostrate hypertrophy (BPH), urinary retention and chronic obstructive pulmonary disease (COPD). He was coded for a urinary catheter present on admission. On 3/31/16, Resident #33 was care planned for his suprapubic catheter (SP-tube inserted through an opening in the lower abdomen that drains urine out of the bladder). There were no recent care plan revisions noted. Interventions included catheter care every shift to include cleaning and positioning of the catheter. Resident #33 ' s annual Minimum Data Set (MDS) dated 11/25/16 indicated he was cognitively intact with verbal behaviors and rejection of care. He required extensive assistance with his activities of daily living (ADLs). A review of January 2017 Treatment Administration Record (TAR) read Resident #33 ' s SP insertion site was cleansed with soap and water, the skin was assessed and a dry clean dressing was applied nightly until 1/29/17 when he went out to the hospital for hematuria (bloody urine). A review of the February 2017 TAR had no initials in place to indicate SP catheter care had been completed since his return from the hospital on 2/2/17. A review of the physician orders for February 2017 revealed the daily SP catheter care was discontinued on 2/2/17. In an interview on 2/23/17 at 10:15 AM, MDS	F 282	Resident # 33□s Suprapubic catheter: MD notified, orders initiated and implemented per physician orders by the facility Director of nursing. Care plan updated on 3/16/2017 by facility MDS Coordinator. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by this practice. On 2/22/17 the Director of Nursing initiated a chart audit on all current residents to ensure that all resident with indwelling catheters had orders initiated, implemented as ordered and care planned. There were only 2 residents who have supra pubic indwelling catheters. The orders were initiated, implemented as per physician orders and the care plans were revised and updated by the MDS nurse coordinator. Systemic Changes On 3/16/17, Education was provided to the admission nurse, the MDS nurses, the Assistant Director of Nursing, and the Director of Nursing by the MDS Nurse Consultant in assessing all residents who are admitted or readmitted to the facility with an indwelling catheter, to ensure that there is written order for the use of the catheter, appropriate diagnosis to support the use of the catheter, treatment and care of the catheter, presence of a revised and updated care plan with focus goals and interventions as appropriate. This information has been integrated into the routine in service(s) for admission	

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F 282	Continued From page 18 nurse #1 stated there was not an order to discontinue his SP catheter care on his re-admission to the facility. In an interview on 2/22/17 at 11:40 AM, the Director of Nursing (DON) stated it was her expectation that the nurses followed the care plan interventions.	F 282	nurses, MDS nurses, Assistant Director, and Director of Nursing and will be reviewed by the Quality Assurance Process to verify that the change is maintained. Monitoring To ensure compliance, Director of Nursing or Unit Manager will monitor this issue using the QA survey tool. The facility will monitor compliance by monitoring admission and readmission physician orders by completing the Admission/Readmission checklist review M-F .The Admission/Readmission review will be completed by reviewing and comparing the Discharge Summary to the Admission orders and current orders in the resident□s EMAR/ ETAR. This audit will continue for 3 months or until otherwise directed by the Quality Of Life team. Reports of this audit will be given by the Director of Nursing to the weekly Quality of Life QA committee and corrective action initiated as appropriate. The Quality of Life committee consists of the Director of Nursing, Administrator, Staff Development Coordinator, Dietary Manager, Minimal Data Assessments Nurse and Health Information Management and meets weekly. Compliance date: 3/17/17	
F 309	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES	F 309		3/17/17

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F 309 SS=D	Continued From page 19 FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff	F 309	F 309 483.24, 483.25(k)(l) PROVIDE	

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F 309	Continued From page 20 and resident interviews, the facility failed to assess a resident for pain and provide pain medication, which resulted in delayed pain relief for one out of three residents (Resident #198). Findings include: Record review revealed Resident #198 was admitted on 2/17/17 with the following diagnosis: right displaced-intertrochanteric femur fracture; coronary artery disease; atrial fibrillation; chronic obstructive pulmonary disease; and major depressive disorder, single episode. The resident was recently admitted and no comprehensive MDS assessment was completed. Review of admission nurse ' s note dated 2/17/17 revealed Resident #198 required assistance with bathing and locomotion. Pain was evaluated and scored 7 out of 10. Nurse ' s note dated 2/18/17 at 6:30 pm revealed the pain assessment was none verbalized or observed, but chronic back pain was documented. Review of the February medication administration record (MAR) revealed pain intervention response was documented once a day, not after each administration of pain medication since admission. The resident ' s 2/20/17 morning dose of Percocet initialed on the MAR was at 10:48 am. The next dose of Percocet initialed on the MAR was 5:30 pm. The Social Worker completed a brief interview for mental status for Resident #198 on 2/22/17 and the score was 13, which revealed an intact cognition. Review of the Resident #198 ' s pain care plan	F 309	CARE SERVICES FOR HIGHEST WELL BEING The facility failed to assess a resident for pain and provide pain medication, which resulted in delayed pain relief for resident #198. The staff nurse was re-educated on the Pain Assessment: Importance of administering pain medication in a timely manner according to the resident□s verbalized/exhibited pain level. Corrective Action for Resident Affected: On 2/23/2017 resident #198 pain was addressed by the staff nurse as evidenced by pain medication was administered. Pain interview was completed on 2/24/2017 by the MDS nurse. Resident was seen by the Physician/Nurse Practitioner on 2/21/2017 and 2/26/2017. On 2/23/2017, the Director of Nursing was educated by the Nurse Consultant on the importance of addressing resident□s pain and also on the Pain Assessment. Nursing staff was also in-serviced on Pain Assessment by the Director of Nursing on 3/16/17. The licensed nurse assigned to the resident that shift was also educated on 3/16/17 on Pain Assessment. Corrective Action for Resident Potentially Affected: All residents have the potential to be affected by this practice. All residents that staff was able to interview were interviewed to determine if they were currently experiencing unresolved pain. Nursing management interviewed staff to determine if any nonverbal residents were	

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F 309	Continued From page 21 initiated on 2/17/17 revealed interventions for staff to implement: "Anticipate my need for pain relief and respond immediately to any complaint of pain; Evaluate the effectiveness of pain interventions; and Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition." An admission physician ' s order for pain medication dated 2/17/17 was Percocet 10-325 milligram 1 tablet every 6 hours as needed for pain (Percocet). On 2/20/17 from 5:05 pm to 5:35 pm Nurse #3 ' s management of Resident #198 ' s request for pain medication was observed. On 2/20/17 at 5:05 pm an interview was conducted with Resident #198. The resident stated she had post-surgical pain in her right leg and her pain level was 9 out of 10. The resident was observed to be breathing hard and had facial grimacing. Resident #198 complained she had used the call light 4 times to ask for pain medication and was waiting a long time, about 30 minutes. Resident #198 stated her last dose of pain medication was mid-morning today. Continued observation on 2/20/17 at 5:10 pm revealed Resident #198 was in her room and put the call light on again and Nurse Aide (NA) #1 answered the resident ' s call light. Resident #198 informed NA #1 she was still waiting for Percocet (pain medication). NA #1 informed the resident that Nurse #3 was passing medications and it would be a few minutes. Resident #198 stated when the pain started if she did not receive pain medication, the pain built up and it did not work	F 309	experiencing non-verbal signs of pain such as : Breathing-labored breathing, hyperventilating, cheyne stokes respiration, Negative vocalizations-moaning, groaning, crying, calling out, Facial expressions-sad/frightened/frowning/grimacing facial expressions, tense, Body language-tensed, distressed, pacing, rigid, fist clenched, knees pulled up, pulling or pushing away, striking out, inconsolable: Distracted, unable to console, distract or reassure. An audit of ¿ 72 residents was completed by the nursing management team by 3/17/2017. All residents were assessed for pain using the pain tool. All residents care plan and kardex was updated to reflect any changes. Systemic Changes: All FT and PT and PRN RN□s, LPN□s, Med Aide, and Med Tech□s was educated on Pain Assessment by the Director of Nursing and Nursing Management on 3/16/17. The Director of Nursing will ensure that any staff member who did not receive the in-service training will not be allowed to work until this is completed. The Pain Assessment training was incorporated into the general orientation program. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.	

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F 309	Continued From page 22 so well. Continued observation on 2/20/17 at 5:21 pm revealed Resident #198 continued to wait in her room for Nurse #3 to provide Percocet. Nurse #3 was observed to move down the hall away from the resident's room and provide medications to other residents. At 5:25 pm Resident #198 depressed the call light again and NA #1 answered. Resident #198 informed NA #1 again that she was in pain. NA #1 walked to Nurse #3 and returned with an answer, "will be right there." On 2/20/17 at 5:35 pm Nurse #3 was observed to state to Resident #198 "here is your pain pill" and provided it to the resident. Resident #198 was observed to complain that her pain was worse because she had waited for pain medication. The resident had a discussion with Nurse #3 about the delay. Nurse #3 did not ask Resident #198 her pain level or assess the resident ' s pain. The resident informed Nurse #3 that when the pain medication was delayed the pain increased and the medication did not work as well. Nurse #3 stated to the resident that she "was busy and had other residents to take care of." Nurse #3 offered an ice pack and the resident accepted. On 2/21/17 at 8:40 am Resident #198 was interviewed; she stated she had pain relief from Percocet and ice last evening. The Percocet and ice was provided again at 8:20 am this morning and the resident was comfortable. Resident #198 stated this was the first time she received Percocet before 9:30 am. Resident #198 stated when she asked for pain medication, it was not given when asked; she frequently had to wait. The resident stated "frequently" meant 30 minutes. The resident also commented that her	F 309	Quality Assurance: The Director of Nursing will monitor this issue using the QA Survey Tool for monitoring Pain Management. Any issues will be reported to the Director of Nursing. This will be done weekly for one month and then monthly for 3 months. Reports will be presented to the weekly QA committee by the Administrator/ whoever to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator. Compliance date: March 17th,2017	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTFIELD REHABILITATION AND HEALTH CENTER	3100 TRAMWAY ROAD SANFORD, NC 27332

(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 309	Continued From page 23	F 309		

morning medications had been late, and that included the as needed Percocet.

An interview was conducted on 2/22/17 at 10:50 am via telephone with Nurse #3. Nurse #3 stated when Resident #198 requested pain medication she checked the time frame for the last dose given and what the pain level was before administration. The pain medication was given during routine medication pass. If a resident requested pain medication during the nurse ' s routine medication pass with another resident, Nurse #3 finished what she was doing and then provided the requested pain medication. Nurse #3 stated that she was passing medications to other residents before providing pain medication to Resident #198 on 2/20/17. Nurse #3 stated she documented pain medication on the MAR and narcotic sheet at the same time.

Resident #198 ' s facility physician was interviewed on 2/22/17 at 11:10 am. The physician stated the goal for pain management was to follow the every 6 hour medication administration as needed order. The Physician stated he did not like to set a schedule for pain medication because the residents could become over-sedated, and they need to participate in therapy. The residents could also be more prone to opiate side effects and complications. The facility ' s physician expectation was that staff follow the every six hours as needed pain medication when requested on a timely basis. The physician stated that his expectation was if the resident requested pain medication before the six-hour-interval, the next dose would need to be provided at six hours after the last dose.

An interview was conducted on 2/22/17 at 3:05

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pm with NA #1 regarding Resident #198 ' s request for pain medication on 2/20/17. NA #1 stated that Resident #198 requested Percocet at 4:00 pm, but Nurse #3 was at lunch. Nurse #3 returned from lunch around 4:15 pm and NA #1 informed her that Resident #198 had requested pain medication. Nurse #3 informed NA #1 that "it was not time for pain medication." NA #1 informed Resident #198 immediately and the resident was not seen by Nurse #3. NA #1 stated that Nurse #3 then passed meds for the hall. NA #1 stated at 4:45 pm Resident #198 requested pain medication again and NA #1 informed Nurse #3. Nurse #3 responded to NA #1 "let me finish with this resident, I will be there in a few minutes." NA #1 informed Resident #198 of the response immediately. NA #1 stated Resident #198 requested pain medication again around 5:05 pm. NA #1 again informed Nurse #3 of Resident #198 ' s request for pain medication. Nurse #3 responded she was "with another resident and needed a few minutes." NA #1 informed Resident #198 of Nurse ' s response within 5 minutes. NA #1 stated Resident #198 requested pain medication again around 5:20 pm, and NA #1 informed Nurse #3. NA #1 stated the Nurse replied "she would be right there" (Nurse #3 was passing medication), and Resident #198 was informed immediately. NA #1 stated that Nurse #3 arrived with "pain medication" after that request at about 5:35 pm. NA #1 indicated that Nurse #3 did not see Resident #198 from 4:00 pm when pain medication was first requested until about 5:35 pm when Nurse #3 provided the pain medication.

An interview was conducted on 2/23/17 with the Director of Nursing (DON) regarding pain management and the pain management care

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F 309	Continued From page 25 plan. The DON stated she expected staff to address pain management, assess the resident, and provide pain medication or other modalities within 10 minutes of request. During the medication pass, the nurse should finish the pass with the current resident and address pain management, not finish the entire hall medication pass and then provide pain medication. Nurse #3 should have assessed and discussed with the resident any delay and timeframe for administration of medication and not to continue to relay information through the nursing assistant if a period of time has passed.	F 309		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review and physician and staff interview, the facility failed to follow through with the treatment for the stage III pressure ulcer on	F 314	F 314 483.25(b)(1)TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	3/17/17

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F 314	Continued From page 26 the right buttock, as recommended by the wound doctor for 1 (Resident #8) of 3 sampled residents reviewed for pressure ulcer. Findings included: Resident # 8 was admitted to the facility on 10/30/16 with multiple diagnoses including sacral pressure ulcer and chronic kidney disease. The admission Minimum Data Set (MDS) assessment dated 11/6/16 indicated that Resident #8 had moderate cognitive impairment and had a stage II pressure ulcer that was present on admission. The assessment also indicated that the resident needed supervision with 1 person physical assist with bed mobility. The discharge MDS assessment dated 11/22/16 indicated that Resident #8 was discharged to home on 11/22/16. The weekly pressure ulcer assessments for Resident #8 were reviewed. The assessment dated 10/31/16 indicated that Resident #8 was admitted with a stage II pressure ulcer on the coccyx. The assessment dated 11/16/16 was completed by Nurse # 8 and it indicated that the resident had developed a stage III pressure ulcer on her right buttock measuring 1 centimeter (cm.) x (by) 1.4 cm. x 0.1 cm. The ulcer had moderate serous exudate. The weekly skin check was completed on Resident #8 on 11/6 and 11/13/16 and there was no mention of any open area on the right buttock. On 11/16/16, Resident #8 was seen by the wound doctor. The notes from the wound doctor indicated that Resident #8 had a stage III pressure ulcer on the right buttock with moderate amount of serous exudate. The treatment plan was to use Calcium Alginate (absorbent wound	F 314	Facility failed to follow through with the treatment for the stage III pressure ulcer on the right buttock of resident #8, as recommended by the wound physician. Resident was discharged on 11/22/2016. Corrective Action for Resident Affected On 2/23/2017 the Director of Nursing completed a medication error form and the wound physician was notified of the transcription error. The licensed nurse that had transcribed the treatment order incorrectly was re-educated by the Director of Nursing on 2/23/17. Corrective Action for Resident Potentially Affected All residents have to potential to be effected by this practice. On 3/01/2017, the Director of Nursing and the Assistant Director of Nursing had verified correct treatment orders for all current residents with wound pressure ulcers with the wound physician. Systemic Changes All FT and PT and PRN RN□s, LPN□s, Med Aide, and Med Tech□s were educated on documentation and transcription by the Director of Nursing on 3/17/17. The Director of Nursing will ensure that any staff member who did not receive the in-service training will not be allowed to work until this is completed. The Documentation and Transcription training was incorporated into the general orientation program. This information has been integrated into the standard	

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F 314	Continued From page 27 dressing)), cover with foam and dry protective dressing and to change the dressing daily. The doctor's orders for Resident #8 were reviewed. There was an order dated 11/17/16 to clean the stage III pressure ulcer on the right buttock with wound cleanser, pat dry and cover with foam and dry protective dressing, and to change the dressing daily. The order did not reflect the Calcium Alginate as recommended by the wound doctor. The care plan for Resident #8 with the revised date of 11/22/16 was reviewed. One of the care plan problems was the pressure ulcer on right buttock. The goal was to minimize the development of pressure ulcers through current interventions over the next 90 days. The interventions included air mattress and chair cushion, assist with frequent position changes and turning for pressure reduction and comfort, and report to nurse immediately if redness, open areas and irritation to skin were noted. The Treatment Administration Record (TAR) for November 2016 was reviewed. The TAR revealed that the treatment to the stage III pressure ulcer on the right buttock was not started until 11/18/16. The treatment provided to the right buttock pressure ulcer was "cleanse with wound cleaner, pat dry and cover with foam and dry protective dressing." The Calcium Alginate was not provided as recommended by the wound doctor. On 2/22/17 at 2:55 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the staff to follow the treatment for pressure ulcers as recommended by the wound doctor. She also indicated that Nurse #8 went	F 314	orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Director of Nursing will monitor this issue using the Pressure Ulcer QA Survey Tool. The Director of Nursing will audit that all wound physician orders are transcribed correctly into the electronic treatment administration record after the weekly wound physician visit. Any issues will be reported to the Administrator. This will be done weekly for one month and monthly for three months or until resolved by Quality Assurance Committee. Reports will be presented to the weekly QA committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator. Compliance date: March 17, 2017	

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F 314	Continued From page 28 with the wound doctor during his wound rounds on 11/16/16. The DON further indicated that Nurse #8 failed to follow the treatment as recommended by the wound doctor. The DON stated that the delay in treatment was due to the fact that the wound doctor made rounds once a week on Wednesday (11/16/16) and the notes were not available to the facility until Friday (11/18/16). Nurse #8 was not available for interview. On 2/23/17 at 9:35 AM, the attending physician of Resident #8 was interviewed. He stated that he expected the facility to follow the recommendations from the wound doctor regarding pressure ulcer treatments.	F 314		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an	F 315		3/17/17

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F 315	Continued From page 29 indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, staff and physician interviews and record review, the facility failed to assess and provide daily care to a suprapubic catheter (SP-tube that drains urine out of the bladder inserted through an opening in the abdomen) for 1 (Resident #33) of 2 residents reviewed for catheters. Findings included Resident #33 was admitted 12/1/15 with cumulative diagnoses of benign prostrate hypertrophy (BPH) urinary retention and chronic obstructive pulmonary disease (COPD). He was coded for a urinary catheter present on admission. Resident #33 was care planned for his urinary catheter on 12/3/15 and then the care plan changed to a SP catheter on 3/31/16. There were no recent revisions noted to the care plan. Interventions included catheter care every shift to	F 315	F 315 483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER On 2/22/2017, resident #33 was noted with his dressing intact to his Suprapubic catheter site dated 2/18/17. No orders to change dressing were in place Corrective Action for Resident Affected On 02/22/17, the Suprapubic catheter site was assessed by Nurse Practitioner. On 2/22/2017 suprapubic catheter care orders were implemented. The resident #33 suprapubic site was gently cleansed with soap and water, the skin was assessed and dry dressing was applied by the staff nurse. Corrective Action for Resident Potentially Affected	

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F 315	Continued From page 30 include cleaning and positioning of the catheter. A review of the electronic physician orders read on 7/18/16, Resident #33 ' s SP catheter insertion site was to be cleansed with soap and water gently, the surrounding skin assessed and the application a clean dry dressing applied every night. Resident #33 ' s annual Minimum Data Set (MDS) dated 11/25/16 indicated he was cognitively intact with verbal behaviors and rejection of care. He required extensive assistance with his activities of daily living (ADLs). A review of January 2017 Treatment Administration Record (TAR) read Resident #33 ' s SP insertion site was cleansed with soap and water, the skin was assessed and a dry clean dressing was applied nightly until 1/29/17 when he went out to the hospital for hematuria (bloody urine). Resident #33 was readmitted 2/2/17 with orders to change the SP catheter flushes from sterile water to normal saline. The only other change in the SP catheter orders was the date the SP catheter was to be changed on the 2nd rather than the 27th of the month. A review of the February 2017 TAR read no SP catheter care had been completed since his return from the hospital on 2/2/17. A review of the physician orders for February 2017 read the daily SP catheter care was discontinued on 2/2/17. In an observation and interview on 2/22/17 at	F 315	All residents have the potential to be affected by this practice. On 2/22/17, one other resident noted also with a suprapubic catheter site, was assessed by the staff Registered Nurse and Nurse Practitioner. Resident was noted with catheter care orders, care plan in place and dressing changed as ordered. On 02/22/17, the Suprapubic Catheter Care in-service was implemented by the Assistant Director of Nursing. Systemic Changes All FT, PT and PRN RN□s, and LPN□s, were educated on Catheter Care on 3/17/17. The Director of Nursing will ensure that any staff member who did not receive the in-service training will not be allowed to work until this is completed. The Catheter Care training was incorporated into the general orientation program. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Director of Nursing will monitor this issue using the Catheter QA Survey Tool. The audit will be completed on all residents with catheters on admission and readmission to the facility. The Director of Nursing will audit that any resident with a catheter will have a Physicians Order, Updated Care Plan, treatment Order, and appropriate diagnosis for the catheter.	

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F 315	Continued From page 31 11:35 AM, Resident #33 ' s had a dressing to his abdomen surrounding the SP catheter insertion site dated 2/18/17. The dressing had dried blood surrounding the insertion site. Resident #33 stated nobody had bother to change his dressing in several days. He stated he was under the impression it was to be changed daily. In an interview on 2/22/17 at 11:35 AM, Nurse #6 stated night shift was responsible for changing the SP catheter dressings. In an interview on 2/22/17 at 11:40 AM, the Director of Nursing (DON) stated somehow the order for the SP catheter care was dropped off the readmission orders for Resident #33 on 2/2/17. The DON stated the reason there was a dressing around the SP catheter site was likely because the nurses had been providing SP catheter care to his catheter for so long but were not documenting it. The DON stated it was her expectation Resident #33 ' s readmission orders for the SP catheter care would have been carried from January 2017. She further stated her expectation that a floor nurse should have noted the missing order and contacted the physician before 2/22/17 when the oversight was discovered. In a telephone interview on 2/22/17 at 3:30 PM, the physician stated it was his expectation that Resident #33 ' s SP catheter insertion site be assessed daily, cleaned daily and a clean, dry dressing applied daily.	F 315	Any issues will be reported to the Administrator. This will be done weekly for one month then monthly for 3 months or until resolved by Quality Assurance Committee. Reports will be presented to the weekly QA committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, Assistant Director of Nursing, MDS Nurse, Admission Nurse, Therapy, Health Information Management, Dietary Manager and the Administrator. Compliance date: March 17, 2017	
F 325 SS=D	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE (g) Assisted nutrition and hydration.	F 325		3/17/17

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F 325	Continued From page 32 (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, staff and physician interviews and record review, the facility failed to monitor a resident with significant weight loss (Resident #111) and failed to implement recommended registered dietician (RD) interventions for a resident with significant weight loss (Resident # 81) for 2 of 3 residents reviewed for nutrition. Findings included: 1. Resident #111 was admitted to the facility on 3/24/16. Review of dietary review on 3/25/16, Resident 111 ' s weight on admission (3/24/16) was 139.2 pounds with her ideal body weight was between 135 and 164 pounds. In a RD note dated 3/28/16, Resident #111 ' s average meal intake was 38% and she was fed by the staff. Her current weight was 138.6. A magic cup (nutritional supplement) was ordered	F 325	F 325 483.25(g)(1)(3)MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE A corrective action for Affected Resident has been accomplished by: On 2/22/17 there was an order implemented per dietary recommendation for Magic Cup twice daily for resident #111. On 2/23/2017 resident # 111 chart was reviewed by Registered Dietician. Resident□s weights and care plans were updated by the dietician. On 2/23/2017 weight was obtained and a new order for Magic Cup to be increased to three times daily. Resident continues to be monitored weekly for weight loss. On 2/22/2017 resident # 81 dietary	

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F 325	Continued From page 33 for every afternoon in between meals. In a RD note on 4/29/16, Resident #111 ' s current weight was 134.6 with the intake varied from 25 to 74 %. She was to receive an additional supplement of medpass 2.0 twice daily along with the magic cup daily. The goal was weight maintenance. A weight change note dated 5/27/16 at 1:59 PM read current weight of 134 pounds. This was a 7.5% weight change since her admission on 3/25/16. Staff were to continue to monitor Resident #111. This note was completed by the dietary manager. A weight change note dated 6/14/16 at 3:59 PM read current weight of 133.2 pounds. This was a 7.5% weight change since her admission on 3/25/16. Staff were to continue to monitor Resident #111. This note was completed by nursing. A review of Resident #111 ' s weights were as follows: Resident #11 ' s weight was 130.8 pounds on 9/1/16. A weight change note dated 9/16/16 at 2:54 AM read current weight of 130.8. Resident #111 was on supplements. Staff will continue to monitor. This note was completed by nursing. Resident #111 ' s weight was 125 pounds on 10/27/16. Resident #111 ' s weight was 126.2 pounds on 11/7/16.	F 325	recommendations for 206 juice and Med pass were reviewed by the physician and the new recommendations were implemented by the Director of Nursing. On 2/23/2017 the Nurse Consultant educated Director of Nursing and Nursing Management team on the importance of completing dietary recommendations in a timely manner. A corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by All current residents that have had nutritional recommendations made by the Registered Dietician (RD) are potentially affected. The Registered Dietician audited residents with significant weight change for the last 6 months. The results of the RD audit revealed that of the 70 residents in the facility, 19 were found to have had significant weight change.Care plans and interventions were reviewed. Nine (9) care plans required updating.The nurse management team will audit all nutritional recommendations made by the RD since January 2017 to ensure that the nutritional recommendation has been addressed by the MD and if agreed to, that it has been put in place for the resident. An audit of 48 nutritional recommendations was completed. 2 of 48 nutritional recommendations were found to be incomplete. One patient had been discharged, and the other corrected. A new process for delivering nutritional	

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F 325	Continued From page 34 Resident #111 ' s weight was 110.6 pounds on 12/1/16.This weight was validated on a reweight on 12/1/16 at 11:00 PM. The quarterly Minimum Data Set (MDS) dated 12/15/16 indicated Resident #111 ' s cognitive status was not assessed and she required extensive assistance with eating. Resident #111 was also coded for a weight loss. Resident #111 ' s weight was 124 pounds on 1/1/17. This weight was validated on a reweight on 1/2/17 at 7:58 PM. Resident #111 was readmitted on 1/20/17 with cumulative diagnoses of cerebral vascular accident (CVA), seizures, hemiplegia and dysphagia. Resident #111 ' s weight was 125 pounds on 1/20/17. Resident #111 ' s weight was 111 pounds on 1/25/17. A review of a dietician note dated 1/29/17 read Resident #111 had significant weight loss since her admission with a body mass index of 19.7. A nutritional supplement was recommended twice daily. A review of the physician orders read an order for Med Pass (nutritional supplement) 120 milliliters twice daily on 1/30/17. Resident #111 ' s weight was 110.8 pounds on 1/30/17. A review of a physician order dated 2/1/17 read	F 325	recommendations to the Director of Nursing was implemented on 3/17/2017. The Registered Dietician emails all nutritional recommendations made to the Director of Nursing and the Dietary Manager. Systemic changes made were: On 3/17/2017 an in-service was conducted by the Clinical Nurse Consultant to the Director of Nursing (DON), Assistant Director of Nursing and Dietary Manager the following topics: " When nutritional recommendations are made by the RD, an email will be sent to the DON and the Dietary Manager on the day the recommendation is made. " The Director of Nursing will obtain physician order and/or approval for the dietary recommendations. " Once a response is received from the MD/NP, the approved dietary recommendations will be put in place within 72 hours of receipt. This information has been integrated into the standard orientation training and in the required in-service refresher courses for al management employees and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility plans to monitor its performance by: The Dietary Manager will monitor this issue using the QA for RD recommendations Tool for monitoring to ensure dietary recommendations made	

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F 325	Continued From page 35 weekly weights were to be done every Wednesday and as needed. Resident #111 ' s weight was 119.4 pounds on 2/1/17. Resident #111 ' s most recent revised care plan dated 2/7/17 read a potential nutritional problem related to receiving a mechanically altered, therapeutic diet with nectar thick liquids. Interventions included the following: monitor Resident #111 ' s weights per facility protocol, notify the physician for sign of dysphagia or refusing to eat, provide fluids, diet as ordered and monitor/record her meal intake. The RD could evaluate and make diet recommendations as needed. An RD defined is a dietitian who has completed special academic and professional requirements to be granted a bachelor degree and passed a registration examination. A review of the documented meal intake percentages from 2/1/17 to 2/18/17 indicated the following: Resident #111 consumed 0-25% of breakfast for 11 days, lunch 12 days and dinner 2 days. Resident #111 consumed 26-50 % of breakfast for 6 days, lunch 2 days and dinner 11 days. Resident #111 consumed 51-76% of her breakfast on 1 day, lunch for 2 days and dinner 1 day. Resident #111 consumed 76-100% of breakfast for zero days, lunch 1 day and dinner for 1 day. There was also 2 documented meal refusals.	F 325	have been implemented timely within 72 hours of receipt from the MD. This will be completed on 5 residents weekly x 4 weeks then monthly x 2 months or until resolved by QOL/QA committee. Reports will be presented to the weekly QA committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, Dietary Manager and the Administrator. Compliance date: March 17th, 2017	

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Resident #111 ' s weight was 110.6 pounds on 2/15/17. There was no reweight to validate this for accuracy.

Resident #111 ' s weight was 107.6 pounds on 2/22/17. There was no reweight to validate this for accuracy.

In a meal observation on 2/22/17 at 12:39 PM, Nursing Assistant (NA) #2 was in the room with feeding Resident #111. The tray card read purred cardiac diet with nectar thick liquids. NA #2 stated she was able to get Resident #111 to eat maybe 10% of her meal and most of the nutritional supplement shake. She stated Resident #111 was a very poor eater, required a lot of coaxing, and rarely ate breakfast and very little lunch.

In a telephone interview on 2/22/17 at 2:50 PM, the RD stated Resident #111 had weight fluctuations but she recently ordered Med Pass and weekly weights. The RD stated it appeared the facility staff did not obtained the weekly weights as ordered on 2/1/17 since there was no documented weight until 2/15/17. The RD stated it was up to the weekly care plan team to alert her to a significant weight loss since she was only at the facility once weekly. The RD verified she had access to the electronic record at any time but she did not routinely go in and check the residents on weekly weights.

In a telephone interview on 2/22/17 at 3:30 PM, the physician stated it was his expectation that the facility monitor residents at risk for significant weight loss and contact him or the RD for interventions. The physician stated he was not aware Resident #111 had lost over twenty pounds

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since September 2016. He stated Resident #111 had a recent hospitalization for pneumonia that could account for some of her weight loss.

In an interview on 2/22/17 at 3:45 PM, the dietary manager (DM) stated she was aware there was an order for Resident #111 to be weighed weekly. She stated she did not always go into the computer weekly to check to see if the weekly weights were done. She stated if she noticed staff were not obtaining the ordered weights, she would email the Director of Nursing (DON) as a reminder for the staff to obtain the weights. She stated there was a daily stand up meeting where accidents or changes in condition were discussed. The DM stated she asked the nursing department to obtain a weight on Resident #111 today.

A review of the electronic assignment to be completed daily by the aides indicated there was a prompt for the aides to weigh Resident #111 every Wednesday initiated on 2/1/17.

In an interview on 2/22/17 at 4:49 PM, the DON stated she and the assistant DON met weekly and went over the residents with weight loss. She stated neither the RD nor the DM were notified of the weekly meetings. The DON stated Resident #111 ' s weight loss was missed and it was her expectation that the aides would have obtained the weekly weights as ordered and it was her responsibility to check the electronic medical record for missing weights and ensure they were obtained.

In an interview on 2/23/17 at 9:00 AM, NA #3 stated Resident #111 ' s appetite varied. NA #3 stated she only ate a few bites of oatmeal. She

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ate approximately 10% of her breakfast tray. NA #3 stated the electronic record would light up if a weekly weight was due on any of her assigned residents.

In an interview on 2/23/16 at 12:15 PM, the Director of Nursing stated it was her expectation Resident #111 would have been monitored for her significant weight loss. She also stated it was her expectation the ordered and care planned interventions be followed for Resident #111.

2. Resident #81 was admitted to the facility on 11/5/13 and readmitted on 12/7/16 with multiple diagnoses that included atrial fibrillation, hypertension, and urinary tract infection.

The dietary assessment dated 12/7/16 indicated Resident #81 had a weight of 150 pounds (lbs). Resident #81 was assessed with the minimal need of staff supervision/cueing for eating. Her nutritional intake varied from 50-100% of her meals. She was on a regular diet with no nutritional supplements.

The admission Minimum Data Set (MDS) assessment dated 12/14/16 indicated Resident #81 had significant cognitive impairment. She required supervision from staff with eating. Resident #81 was assessed with no swallowing issues and no dental concerns. Her documented weight was 145 lbs.

The Registered Dietician (RD) progress note dated 2/10/17 indicated Resident #81 had a 10% weight loss in the past month with a current weight of 137 lbs. Her nutritional intake over the past month was 53-73% of her meals. The RD

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recommended 60 milliliters (ml) Med Pass 2.0 (fortified nutritional shake) three times daily and 206 Juice (high protein juice) or Ensure Clear (nutritional protein drink) on her breakfast tray for additional calories.

A Nutrition Recommendation form was completed by the RD on 2/10/17 for Resident #81. The recommendation indicated Resident #81 had significant weight loss in the past month and was recommended 206 Juice or Ensure Clear on her breakfast meal tray and 60ml Med Pass 2.0 to be administered three times daily with medication pass. This physician reviewed the form, indicated his agreement with the recommendation, and signed the form on 2/10/17.

A review of the physician's orders in the electronic medical record and the hard copy medical record for Resident #81 revealed no physician's orders for 206 Juice or Ensure Clear on her breakfast meal tray or for 60ml Med Pass 2.0 three times daily.

A review of the February Medication Administration Record (MAR) revealed 60ml Med Pass 2.0 three times daily was not on Resident #81's MAR.

An observation was conducted on 2/22/17 at 8:43 AM of Resident #81 at her breakfast meal. Resident #81 was delivered her breakfast meal tray in her room. The tray was observed with no 206 Juice or Ensure Clear. The dietary slip for Resident #81 was observed and it had not included any nutritional supplements.

An interview was conducted on 2/22/17 at 9:01 AM with Nurse #2. She reviewed the MAR for

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Resident #81 and revealed she was not administered any nutritional supplements. She indicated if Resident #81 received Med Pass 2.0 it would have been included on her MAR.

An interview was conducted on 2/22/17 at 9:04 AM with the Dietary Manager (DM). She indicated if a resident received a nutritional supplement with their meal that it was indicated on the resident's dietary slip. She stated if there was no documentation of a nutritional supplement on the dietary slip then no nutritional supplement was served to the resident. The dietary slip for Resident #81's breakfast was reviewed with the DM. She revealed Resident #81 received no nutritional supplement with her breakfast.

A phone interview was conducted with the RD on 2/22/17 at 2:45 PM. She reviewed the process that occurred when she made a dietary recommendation. She stated she wrote a recommendation on a hard copy Nutrition Recommendation form and placed it in the Director of Nursing's mailbox. She indicated it was usually within a week that the recommendation was reviewed by the physician and implemented if the physician was in agreement. The recommendation that was completed on 2/10/17 for Resident #81 was reviewed with the RD. She reported she recalled making the recommendation for Med Pass 2.0 three times daily and 206 Juice or Ensure Clear with breakfast for Resident #81 due to her significant weight loss. She revealed she had not known the recommendations were not implemented for Resident #81. The RD indicated her expectation was for the recommendation to have been implemented when the physician reviewed it and agreed on 2/10/17.

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F 325	Continued From page 41 An RD note dated 2/22/17 indicated she requested a follow up on the previous recommendation for Med Pass 2.0 and 206 juice for Resident #81. A physician's order dated 2/22/17 indicated 60ml Med Pass 2.0 three times daily and 206 Juice once daily for Resident #81. A DM note dated 2/22/17 indicated Resident #81 had 206 juice added to every breakfast meal. An interview was conducted with the Director of Nursing (DON) on 2/22/17 at 3:40 PM. She reviewed the process that occurred when the RD made a dietary recommendation. She indicated the recommendation was made on a hard copy Nutrition Recommendation form and was given to her either by hand or placed in her mail box. She reported she then obtained the physician's order and entered it into the electronic medical record. The dietary recommendation dated 2/10/17 for Resident #81 was reviewed with the DON. She stated she found this recommendation in her mail box today. She revealed the recommendation had been missed and Resident #81 had not received Med Pass 2.0, 206 Juice, or Ensure Clear. She indicated it was her expectation for dietary recommendations to be implemented within 2 business days.	F 325		
F 334 SS=E	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that-	F 334		3/17/17

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F 334	Continued From page 42 (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. (2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;	F 334		

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F 334	Continued From page 43 (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide the resident and/or Responsible Party (RP) with education of the benefits and potential side effects of the influenza vaccine prior to offering the vaccine to 5 of 5 residents (Residents #22, #73, #82, #89, and #109). The findings included: The facility's policy on the influenza vaccination dated 7/1/02 and most recently revised on 4/2011 was reviewed. The policy read, in part: - Explain the risk and benefits of receiving the vaccine to the resident and/or responsible party (RP). This can be done via mail if necessary. - Obtain a signed Influenza Consent/Declination Form for every resident.	F 334	F334 483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATION The facility failed to provide the resident and/or Responsible Party with education of the benefits and potential side effects of the Influenza vaccine prior to offering the vaccine to residents□ #22,#73,#82,#89 and #109. Corrective Action for Resident Affected: As of 3/17/2017 the risk and benefits of receiving the Influenza vaccine were explained by the Admissions Nurse and Assistant Director of Nursing to residents #22, #73, #82, #89 and #109 or to the resident□s responsible party. A physician order was placed for residents□ #22, #73,	

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F 334	Continued From page 44 - This should be completed between October 1/when the vaccine becomes available and November 30 of every year. 1. Resident #22 was readmitted to the facility on 4/18/16. The quarterly Minimum Data Set (MDS) assessment dated 7/17/16 indicated Resident #22 had moderate cognitive impairment. A review of the medical record for Resident #22 revealed no documentation that education regarding the benefits and potential side effects of the influenza vaccine were given to the Resident #22 or his RP prior to offering the vaccine for the 2016-2017 influenza season. The Resident Vaccination Record for the 2016-2017 influenza season for Resident #22 had no signature to indicate the consent or declination of the vaccine. The form was also not dated. An interview was conducted with the Admissions Nurse on 2/23/17 at 11:10 AM. She stated the Director of Nursing (DON) had requested her assistance with influenza vaccine education and consent/declination forms for the 2016-2017 influenza season. She indicated she completed this task for most of the residents that resided in the facility. She reported she began this process sometime in October of 2016. She stated her normal procedure for providing education regarding the vaccine was to give the resident and/or RP the highlights of the benefits and side effects. She indicated she was not able to recall the specifics of what she had said to the residents and/or RPs. The Admissions Nurse revealed she	F 334	#82, #89 and #109 that had consents signed by the resident or their responsible party and that had received the Influenza vaccination. Corrective Action for Resident Potentially Affected: All residents have the potential to be affected by this practice. On 2/23/2017 the Nurse Consultant educated the Director of Nursing on the Immunization Policy. On 2/23/2017 the Director of Nursing educated the Admission Nurse, Admission and Marketing Director and the Health Information Manager on the Immunization Policy. The Admission Nurse completed an audit as of 3/17/2017 to ensure that consent or declination was received and those residents who had consented, received their immunizations. Of the 33 patients audited, none had been given the education pamphlet. The Admissions Nurse and Assistant Director of Nursing contacted the residents and responsible party of the residents identified, and explained the risks and benefits of receiving the vaccine as is outlined on the educational pamphlet. Influenza orders were obtained from the facilities medical director. Systemic Changes: Influenza and Pneumococcal Vaccines will be addressed in the admissions process within the first 72 hours upon arrival. The Admissions and Marketing Coordinator, upon endorsement by the resident or responsible party will provide the consent or declination to the Admission Nurse to obtain an order from the physician. The	

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F 334	Continued From page 45 had not utilized the Vaccine Information Sheet (VIS) to provide education to the residents and/or RPs. She additionally revealed she had not seen or read the VIS herself. She stated this was not her normal duty and her training had not included any information regarding the VIS. The interview with the Admissions Nurse continued on 2/23/17 at 11:13 AM. The Resident Vaccination Record for Resident #22 was reviewed with the Admissions Nurse. She stated she completed this form. She reported she contacted Resident #22's RP by phone to see if she consented to the administration of the influenza vaccine for Resident #22. She revealed she forgot to date the form and she had not obtained the signature of Resident #22's RP because she completed the form by phone. The Admissions Nurse verified she had not provided the required VIS to Resident #22 or his RP. An interview was conducted with the DON on 2/23/17 at 12:10 PM. She stated she expected the VIS to be provided to the resident and/or RP prior to offering the influenza vaccine. 2. Resident #73 was admitted to the facility on 11/6/15. The quarterly MDS assessment dated 8/11/16 indicated Resident #73's cognition was intact. A review of the medical record for Resident #73 revealed no documentation that education regarding the benefits and potential side effects of the influenza vaccine were given to the Resident #73 or her RP prior to offering the vaccine for the 2016-2017 influenza season.	F 334	Admission Nurse will explain to the resident and/or the responsible party on the risk and benefits of the Influenza and Pneumococcal Vaccine and will administer the vaccine(s) appropriately. Quality Assurance: Health Information Manager will monitor this issue using the QA Survey Tool for monitoring Immunizations weekly through an admission/resident audit. This will be monitored on all resident new admissions weekly for one month and then monthly for three months. Reports will be presented to the weekly QA committee by the Administrator/ whoever to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator. . Date of Compliance: March 17th, 2017	

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The Resident Vaccination Record for the 2016-2017 influenza season for Resident #73 had no signature to indicate the consent or declination of the vaccine. The form was also not dated.

An interview was conducted with the Admissions Nurse on 2/23/17 at 11:10 AM. She stated the DON had requested her assistance with influenza vaccine education and consent/declination forms for the 2016-2017 influenza season. She indicated she completed this task for most of the residents that resided in the facility. She reported she began this process sometime in October of 2016. She stated her normal procedure for providing education regarding the vaccine was to give the resident and/or RP the highlights of the benefits and side effects. She indicated she was not able to recall the specifics of what she had said to the residents and/or RPs. The Admissions Nurse revealed she had not utilized the VIS to provide education to the residents and/or RPs. She additionally revealed she had not seen or read the VIS herself. She stated this was not her normal duty and her training had not included any information regarding the VIS.

The interview with the Admissions Nurse continued on 2/23/17 at 11: 14 AM. The Resident Vaccination Record for Resident #73 was reviewed with the Admissions Nurse. She stated she completed this form. She reported she contacted Resident #73's RP by phone to see if he consented to the administration of the influenza vaccine for Resident #73. She revealed she forgot to date the form and she had not obtained the signature of Resident #73's RP because she completed the form by phone. The Admissions Nurse verified she had not provided

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F 334	Continued From page 47 the required VIS to Resident #73 or her RP. An interview was conducted with the DON on 2/23/17 at 12:10 PM. She stated she expected the VIS to be provided to the resident and/or RP prior to offering the influenza vaccine. 3. Resident #82 was readmitted to the facility on 11/27/13. The quarterly MDS assessment dated 9/10/16 indicated Resident #82 had poor short term memory, poor long term memory, and was rarely/never understood. A review of the medical record for Resident #82 revealed no documentation that education regarding the benefits and potential side effects of the influenza vaccine were given to the Resident #82 or his RP prior to offering the vaccine for the 2016-2017 influenza season. The Resident Vaccination Record for the 2016-2017 influenza season for Resident #82 had no signature to indicate the consent or declination of the vaccine. The form was also not dated. An interview was conducted with the Admissions Nurse on 2/23/17 at 11:10 AM. She stated the DON had requested her assistance with influenza vaccine education and consent/declination forms for the 2016-2017 influenza season. She indicated she completed this task for most of the residents that resided in the facility. She reported she began this process sometime in October of 2016. She stated her normal procedure for providing education regarding the vaccine was to	F 334		

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give the resident and/or RP the highlights of the benefits and side effects. She indicated she was not able to recall the specifics of what she had said to the residents and/or RPs. The Admissions Nurse revealed she had not utilized the VIS to provide education to the residents and/or RPs. She additionally revealed she had not seen or read the VIS herself. She stated this was not her normal duty and her training had not included any information regarding the VIS.

The interview with the Admissions Nurse continued on 2/23/17 at 11:15 AM. The Resident Vaccination Record for Resident #82 was reviewed with the Admissions Nurse. She stated she completed this form. She reported she contacted Resident #82's RP by phone to see if she consented to the administration of the influenza vaccine for Resident #82. She revealed she forgot to date the form and she had not obtained the signature of Resident #82's RP because she completed the form by phone. The Admissions Nurse verified she had not provided the required VIS to Resident #82 or her RP.

An interview was conducted with the DON on 2/23/17 at 12:10 PM. She stated she expected the VIS to be provided to the resident and/or RP prior to offering the influenza vaccine.

4. Resident #89 was admitted to the facility on 5/27/14.

The quarterly MDS assessment dated 9/14/16 indicated Resident #89 had moderate cognitive impairment.

A review of the medical record for Resident #89 revealed no documentation that education

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regarding the benefits and potential side effects of the influenza vaccine were given to the Resident #89 or his RP prior to offering the vaccine for the 2016-2017 influenza season.

The Resident Vaccination Record for the 2016-2017 influenza season for Resident #89 had no signature to indicate the consent or declination of the vaccine. The form was also not dated.

An interview was conducted with the Admissions Nurse on 2/23/17 at 11:10 AM. She stated the DON had requested her assistance with influenza vaccine education and consent/declination forms for the 2016-2017 influenza season. She indicated she completed this task for most of the residents that resided in the facility. She reported she began this process sometime in October of 2016. She stated her normal procedure for providing education regarding the vaccine was to give the resident and/or RP the highlights of the benefits and side effects. She indicated she was not able to recall the specifics of what she had said to the residents and/or RPs. The Admissions Nurse revealed she had not utilized the VIS to provide education to the residents and/or RPs. She additionally revealed she had not seen or read the VIS herself. She stated this was not her normal duty and her training had not included any information regarding the VIS.

The interview with the Admissions Nurse continued on 2/23/17 at 11:16 AM. The Resident Vaccination Record for Resident #89 was reviewed with the Admissions Nurse. She stated she completed this form. She reported she contacted Resident #89's RP by phone to see if

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she consented to the administration of the influenza vaccine for Resident #89. She revealed she forgot to date the form and she had not obtained the signature of Resident #89's RP because she completed the form by phone. The Admissions Nurse verified she had not provided the required VIS to Resident #89 or her RP.

An interview was conducted with the DON on 2/23/17 at 12:10 PM. She stated she expected the VIS to be provided to the resident and/or RP prior to offering the influenza vaccine.

5. Resident #109 was admitted to the facility on 2/26/16.

The quarterly MDS assessment dated 9/2/16 indicated Resident #109's cognition was moderately impaired.

A review of the medical record for Resident #109 revealed no documentation that education regarding the benefits and potential side effects of the influenza vaccine were given to the Resident #109 or his RP prior to offering the vaccine for the 2016-2017 influenza season.

The Resident Vaccination Record for the 2016-2017 influenza season was signed and dated by Resident #109 on 10/20/16.

An interview was conducted with the Admissions Nurse on 2/23/17 at 11:10 AM. She stated the DON had requested her assistance with influenza vaccine education and consent/declination forms for the 2016-2017 influenza season. She indicated she completed this task for most of the residents that resided in the facility. She reported she began this process sometime in October of

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F 334	Continued From page 51 2016. She stated her normal procedure for providing education regarding the vaccine was to give the resident and/or RP the highlights of the benefits and side effects. She indicated she was not able to recall the specifics of what she had said to the residents and/or RPs. The Admissions Nurse revealed she had not utilized the VIS to provide education to the residents and/or RPs. She additionally revealed she had not seen or read the VIS herself. She stated this was not her normal duty and her training had not included any information regarding the VIS. The interview with the Admissions Nurse continued on 2/23/17 at 11:17 AM. The Resident Vaccination Record for Resident #109 was reviewed with the Admissions Nurse. She stated she completed this form. She reported she met with Resident #109 in person to see if he consented to the administration of the influenza vaccine. She verified she had not provided the required VIS to Resident #109. An interview was conducted with the DON on 2/23/17 at 12:10 PM. She stated she expected the VIS to be provided to the resident and/or RP prior to offering the influenza vaccine.	F 334		
F 371 SS=D	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 371		3/17/17

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F 371	Continued From page 52 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations, manufacturer ' s recommendation, and staff interviews, the facility failed to discard dietary supplement after expiration in 1 of 3 food storage refrigerators. Findings include: An observation was performed on 2/21/17 at 11:05 am of the food storage and refrigerator on Hall 100. There was dietary supplement container open and dated 2/11/17. An interview was conducted on 2/21/17 at 11:40 am of the Dietary Manager (DM) regarding the use, storage, and expiration of dietary supplement. DM stated that the nurse opened, dispensed, and dated for expiration the dietary supplement. Dietary supplement was stored in the refrigerator after opening on the Units. An opened dietary supplement container was good for 48 hours, then discarded. An interview was performed on 2/21/17 at 11:50 am with Nurse #3 regarding hall 100 ' s refrigerator storage of dietary supplement. Nurse	F 371	F371 Corrective Action for Resident Affected The expired Med Pass supplement was discarded immediately. The Director of Nursing audited both nourishment rooms and medication carts n 2/23/17. No other expired Med Pass was found. Corrective Action for Resident Potentially Affected All residents have the potential to be affected by this alleged deficient practice. An audit tool was implemented on 3/10/17 to monitor safe handling of Medication Pass supplements. Systemic Changes An in-service was conducted on 3/16/17 by the Director of Nursing for all licensed nurses. The in-service topic included:	

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F 371	Continued From page 53 #3 stated nursing was responsible to administer and document the discard date of the dietary supplement container after opening and discard as when expired. The dietary supplement was only usable for a couple of days. An interview was conducted on 2/23/17 at 12:30 pm with Director of Nursing (DON) regarding the discard of expired nutritional supplements in hall refrigerators and on medication carts. DON stated that her expectation was nursing was to check for expired supplements every day and discard as appropriate.	F 371	Proper storage, assessing for expiration date and handling of medication pass supplements. Any licensed nurse who did not receive the in-service training will not be allowed to work until training has been completed. Information presented included proper storage of the product, dating of the product once opened and shelf life of product once opened. The monitoring tool/audit will be completed by the Director of Nursing or Assistant Director of Nursing and findings will be reported to the weekly/monthly QA meeting by the Director of Nursing. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all licensed nurses and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Director of Nursing or Assistant Director of Nursing will monitor this issue using the "QA Audit Medication Pass Supplements tool. This will be completed weekly for 4 weeks and then once a month for 3 months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. Results of the audits will then be shared in the Quarterly QA Meeting. Compliance Date: March 17th, 2017	
F 431	483.45(b)(2)(3)(g)(h) DRUG RECORDS,	F 431		3/17/17

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F 431 SS=D	Continued From page 54 LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws,	F 431		

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F 431	Continued From page 55 the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to date multi dose medications in 1 (200 hall) of 3 medication carts observed. Findings included: The facility's policy on medication storage dated 2/20/14 was reviewed. The policy indicated that all insulins and injections must have a date opened sticker attached and the date and initials of the person opening the medication must be written on the sticker. The policy also indicated that all insulins except Lantus (used to treat diabetes mellitus) were good for 28 days after opening if stored in room temperature. The policy also indicated that all injections were good for 30 days in refrigerator if it was a multi dose vial. On 2/23/17 at 11:10 AM, the 200 hall medication cart was observed. There was an opened vial of multi dose Lidocaine (local anesthetic) 200 milligrams (mgs.) /20 milliliter (ml) and a used Humalog (fast acting insulin) pen, stored in the medication drawer that were undated.	F 431	F 431(483.45(b)(2)(g)(h) DRUG RECORDS,LABEL/STORE DRUGS &BIOLOGICALS On 2/23/17 the 200 hall medication cart was observed. There was an open vial of multi- dose Lidocaine (local anesthetic) 200milligrams/20 milliliter and an opened Humalog (fast acting insulin) pen, stored in the medication drawer that were not dated Corrective Action for Resident Affected: On 2/23/17 the opened unlabeled vial of Lidocaine and opened Humalog pen on the 200 hall medication cart were removed from the medication cart by the Director of Nursing and discarded. Nurse was provided education by the Director of Nursing on the facility policy of checking for expiration dates and on labeling vials when opened. Corrective Action for Resident Potentially Affected:	

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F 431	Continued From page 56 On 2/23/17 at 11:15 AM, Nurse #5 was interviewed. She stated that the Lidocaine and the Humalog should have been dated when opened. She observed the Lidocaine vial and the Humalog pen and acknowledged that they were not dated. Nurse #5 stated that she would discard the opened Lidocaine vial and Humalog pen. On 2/23/17 at 11:45 AM, the Director of Nursing (DON) was interviewed. The DON stated that the nurses were responsible for checking the medication carts for expired and undated medications daily. She also stated that the administrative nursing staff checked the medication carts randomly. The DON indicated that she expected the nurses to date multi-dose medications including insulins.	F 431	All residents have the potential to be affected by this practice. On 2/23/17 all medication carts, medications rooms and medication storage rooms were assessed by Director of Nursing for any unlabeled, undated, expired medications and opened vials. All identified expired medications were discarded immediately and any non-labeled opened vials were discarded. Systemic Changes: On 2/23/2017 the Assistant Director of Nursing implemented the in service on Storage and Labeling of Medications for full time, part time and prn nursing staff on the process of discarding expired medications and dating vials when they are opened. The Director of Nursing will ensure that any staff member who did not receive the in-service training will not be allowed to work until completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance: The Director of Nursing will monitor this issue using the QA Survey Tool for monitoring Storage of Drugs & Biologicals observing for any expired medications and any opened vials that are not dated. Any issues will be reported to the Administrator. This will be done weekly for one month and then monthly for 3 months. Reports will be presented to the weekly QA committee by the	

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F 431	Continued From page 57	F 431	Administrator/ whoever to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing , Assistant Director of Nursing, MDS Nurse, Therapy, Health Information Manager, Dietary Manager and the Administrator. Compliance date: March 17, 2017	