STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 03/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(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 000	INITIAL COMMENTS The Statement of Deficiencies was amended on 03/28/2017 where the scope and severity of tags F281 and F42 was changed into an E.	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.	F 157		4/14/17

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

Electronically Signed | 03/23/2017

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F 157	Continued From page 1 (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review, physician interview and staff interviews, the facility failed to notify the physician of an incident until the next day which resulted in delay of physician assessment and orders for 1 of 1 sampled resident (Resident #36). Findings included: The record review revealed Resident #36 was admitted on 8/19/2010 and expired on 2/17/2017. The last comprehensive annual minimum data set (MDS) assessment was dated 1/9/17. Resident #36 was coded on the assessment as total care for all activities of daily living and nutrition and hydration intake. The resident's diagnoses were: abnormal weight loss, hemorrhoids, constipation, dysphagia, insomnia, gastro-esophageal reflux, polyarthritis, anxiety, depression, and dementia with behaviors. The resident was in-facility, admitted to Hospice services on 2/7/17.	F 157	F Tag 157 Notification of Changes All occurrence/incident reports will be reviewed daily, Monday-Friday, by the Clinical team in the Clinical Morning Meeting. Occurrences that happen Saturday and Sunday will be reviewed in the Morning Meeting on Monday. The Clinical Team consists of the Director of Nursing, Staff Development Coordinator, the Wound Care Nurse and the MDS Coordinator. All Licensed Nurses, including weekend and prn staff, will be in-serviced regarding Notification of Changes to the Physician by the Director Of Nursing (DON) or the Staff Development Coordinator. In-services were started on 3/7/17 and will be completed by 4/7/17. The in-service will include: • Facility Policy for reporting	

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F 157	Continued From page 2 The facility's occurrence investigation - quality assurance tool (OI/QAT) dated 2/7/17 was reviewed. The OI/QAT documented that a "report was provided to the on-coming administrative nurse on 2/7/17 at 5:30 am. During incontinence care a foreign cloth object was taken out of Resident #36's rectum with a bowel movement. The cloth was sized at 5-6 cm (centimeters) in length with strings, believed to be a piece of wash cloth. Treatment provided was to monitor bowel movement output and bowel sounds, a KUB (an abdominal x-ray that included kidneys, ureters, and bladder), and frequent rounds. The resident was observed at times chewing or gnawing on bed linen when in bed. The resident was unable to verbalize what had happened. The resident's assessment was alert and oxygen saturation at 95-96%. The occurrence was reported on shift report, verbal report, 24-hour summary, 24-hour board, and the Director of Nursing (DON) was notified. The root cause determined to be the resident's dementia and confusion, and the resident was known to attempt to eat foreign objects." Nurse #1 signed the occurrence form on 2/7/17. A review was conducted of a nurse's note signed by Nurse #1 dated 2/7/17 at 11:00 am which was designated as a late entry for 2/6/17. The note specified NA #1 reported Resident #36 had a foreign body consisted of what was believed to be a piece of wash cloth with stool in his rectum on 2/6/17 at 5:30 am. According to nurse's note dated 2/7/17 at 12:00 pm signed by Nurse #1, Physician #1 was notified of the incident via telephone and a KUB was ordered.	F 157	occurrences/changes to physician in a timely manner • Procedure o All accidents/ incident must be reported to department supervisors and incident form completed on the shift that it occurred. o Nurse must complete their part of the incident report completely prior to the end of the shift. o Physician is to be notified of any incident resulting in injury or unusual occurrence after the resident is assessed. Notification must take place prior to the end of shift in which the incident occurred. Document any new orders on a telephone order sheet and transcribe appropriately. A nurses' note is to be made in the medical record stating physician was notified. A new Incident Log was developed on 3/8/17 and revised on 3/24/17. This new log is designed to validate notification of the physician as well as all other aspects of the incident. It will also serve as an audit tool and will be updated daily by the Administrator or Director of Nursing, Monday through Friday in the morning clinical meeting. The Administrator will bring the results of the Incident Log to the monthly QAPI meetings until 100% compliance is sustained for three months.	

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On 2/27/17 at 4:40 pm, an interview was conducted with Nurse #1. She stated Physician #1 was notified of the incident via telephone on 2/7/17 and a KUB was ordered. Nurse #1 stated she believed Resident #36 was stool impacted. She stated Physician #1 ordered Lactulose 17 grams mixed in liquid twice a day for three days and the bowel protocol on 2/10/17.

On 3/1/17 at 10:35 am, an interview was conducted with Physician #1. The physician stated he discussed this incident with the Administrator and believed that the wash cloth was at the rectum. If the cloth was inside the rectum, this type of care was a violation of how residents are cleaned. Physician #1 stated that consequences would not be an obstruction; Resident #36 was constipated. Physician #1 stated that the consequences of having a cloth in the rectum was pain and suffering.

An interview was conducted on 3/1/17 at 3:32 pm with the Director of Nursing (DON) who stated she was informed about the incident late in the day on 2/6/17, about 5:30 pm. Nurse #1 informed the DON as she was leaving. The DON instructed Nurse #1 to complete an incident report and instructed NA #1 to write a statement. The DON stated Physician #1 was not notified of the incident until 2/7/17 by Nurse #1. Physician #1 gave orders for a KUB, enema and something else she could not remember, but the goal was to get Resident #36 ' s bowels moving.

An interview was conducted on 3/1/17 at 3:47 pm with the facility Administrator. The Administrator was made aware of the cloth in Resident 36's rectum by NA #3 on 2/7/17 at 9:30 am. The DON was aware of the incident 2/6/17 at about 5:30

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F 157	Continued From page 4 pm, but had not informed the Administrator. Physician #1 was notified on 2/10/17. The Administrator stated she expected staff to report incidences to her immediately. An interview was conducted on 3/3/17 at 9:19 am via telephone with Physician #1 about his communication with facility staff for Resident #36's orders after the incident. Physician #1 stated that he spoke to the nurse and was informed about the incident on 2/7/17 about mid-day. The physician provided Nurse #1 orders for constipation and KUB, and stated that he had concerns, to rule out abuse and to make sure an investigation was conducted. Physician #1 stated he believed the cloth was placed in the rectum, possibly during dis-impaction, which was unusual. Physician #1 stated he could not remember if he spoke to the Director of Nursing.	F 157		
F 159 SS=D	483.10(f)(10)(i)-(iv) FACILITY MANAGEMENT OF PERSONAL FUNDS (f)(10)(i) …If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (f)(10)(ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled	F 159		4/14/17

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accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund.

(B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund.

(f)(10)(iii) Accounting and records.
(A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident’s personal funds entrusted to the facility on the resident’s behalf.

(B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

(C)The individual financial record must be available to the resident through quarterly statements and upon request.

(f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits-
(A) When the amount in the resident’s account

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F 159	Continued From page 6 reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on resident interview and staff interview, the facility failed to provide residents access to their personal funds on the weekends for 1 of 8 residents reviewed with personal funds (Resident #39). The findings included: Resident #39 was admitted to the facility on 10/20/15. The annual Minimum Data Set (MDS) assessment dated 10/18/16 indicated his cognition was intact. An interview was conducted with Resident #39 on 2/27/17 at 11:22 AM. He indicated he had a personal fund account with the facility. He stated banking hours were Monday through Friday and he was unable to access his funds over the weekend. An interview was conducted with the Administrator on 3/1/17 at 2:37 PM. She stated the facility had been without a Business Office Manager (BOM) since she began her position as the Administrator at the facility on 8/31/16. The Administrator indicated she and the Human Resources Manager had been sharing the duties of the BOM. She confirmed Resident #39 had a personal fund account with the facility. She stated that residents were able to access their	F 159	F159 Facility Management of Resident Funds A new petty cash system has been implemented to ensure residents have access to their personal funds after business hours and on holidays and weekends. The petty cash system will be managed by the Nursing Supervisor or the licensed nurse on the Tanglewood wing. A new process has been put in place to allow the residents to have access to their personal funds after business hours, on weekends and holidays. Business Office Manager (BOM), personally spoke with resident # 39 on 4/4/17 and explained to him the process to access his funds on the weekends and holidays. He verbalized understanding. Residents were notified verbally during the Resident Council Meeting on 4/3/2017 by Activity Director. The Activity Director and/or the BOM will also speak individually with residents having resident fund monies by 4/14/17. Families and Representatives of residents with dementia or cognitive impairment will be	

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F 159	Continued From page 7 funds between 8:00 AM and 5:00 PM on Monday through Friday. She indicated that residents who needed money over the weekend usually requested money on Friday. The Administrator revealed the facility had no process in place for residents to access their personal fund accounts over the weekend.	F 159	notified by letter from the Business Office Manager by 4/14/2017. A record of each transaction will be made by the Nursing Supervisor or Tanglewood nurse at the time of the transaction. The BOM will reconcile the record daily Monday through Friday. Monday the BOM will reconcile transactions made on the week end to ensure the protection of resident funds. Licensed nurses, including weekend and prn nurses, will be in-serviced by the Administrator or the BOM on the new procedure by 4/14/17. The BOM or Administrator, will reconcile cash and withdrawals daily, Monday through Friday, and post such information to each resident□s ledger. She will also replace any cash withdrawn from the petty cash box. Any discrepancies or disputes will be promptly reported to the Administrator. One of the department managers will randomly conduct an interview of five (5) residents per week for four (4) consecutive weeks to determine if they were able to access their personal funds after normal business hours or during the weekend or holidays. Random audits of after hour and week end banking will continue monthly for a minimum of three (3) months. Audit results will be brought to the monthly QAPI Meetings by the BOM. The plan of correction and audit results will be reviewed by the QAPI Committee during monthly meetings. The QAPI Committee will determine continued need for auditing after four (4) months.	

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F 159	Continued From page 8	F 159	Completion Date is 4/14/17	
F 160 SS=B	483.10(f)(10)(v) CONVEYANCE OF PERSONAL FUNDS UPON DEATH (v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to convey personal fund account balances within 30 days of the resident's death for 4 of 4 residents reviewed (Residents #30, #38, #75, and #129). The findings included: 1. Resident #30 was admitted to the facility on 9/8/15. A review of the medical record indicated Resident #30 expired on 10/30/16. A review of Resident #30's personal fund account statement indicated she had a balance $101.00 at the time of her death on 10/30/16. On 2/17/17 a check was written in the amount of $101.00 to Resident #30's Responsible Party (RP). This was 111 days after Resident #30's date of death. An interview was conducted with the Administrator on 3/1/17 at 2:37 PM. She stated the facility had been without a Business Office Manager (BOM) since she began her position as the Administrator at the facility on 8/31/16. The	F 160	F160 Conveyance of Personal Funds after Death The Business Office Manager refunded a check in the amount of $101.00 to Resident #30's estate on 3/21/2017. Review of the statements for Resident # 38's account, found that no refund is required as a bookkeeping error had recorded the deposit twice. A refund check will be sent to Resident #75 in the amount of $3.00 on 4/6/17 by the Business Office Manager. The Business Office Manager sent a refund check in the amount of $1,028.76 to the estate of Resident #129 on 4/5/17. The Business Office Manager and Administrator completed an audit of	4/14/17

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F 160	Continued From page 9 Administrator indicated she and the Human Resources Manager had been sharing the duties of the BOM. A second interview was conducted with the Administrator on 3/1/17 at 3:40 PM. She indicated her expectation was for the conveyance of personal fund account balances to be completed within 30 days of the resident's date of death. She reported the facility had an as needed (PRN) staff member assisting with the conveyance of personal funds. An interview was conducted with PRN Administrative Staff #1 on 3/1/17 at 5:35 PM. She indicated she worked about 6-8 hours per week at the facility assisting with business office tasks. She stated she began this PRN work sometime in September of 2016. She indicated her job duties included the conveyance of personal fund account balances for residents who had expired. She reported she conveyed the personal fund account balances to the Clerk of Courts within 30 days of the resident's date of death. The interview with PRN Administrative Staff #1 continued on 3/1/17 at 5:38 PM. Resident #30's date of death (10/30/16), the personal fund account statement with a balance of $101.00 on 10/30/16, and the $101.00 check dated 2/17/17 that was made out to Resident #30's RP were reviewed with PRN Administrative Staff #1. She revealed this conveyance of funds was late. She also revealed she conveyed the funds to Resident #30's RP rather than to the Clerk of Courts. She indicated she should have conveyed the funds to Clerk of Courts within 30 days of Resident #30's date of death.	F 160	discharged residents in the last six months on 3/22/17. Of 64 residents discharged 6 residents were identified to still have funds in their Resident Trust Fund past 30 days. All funds were conveyed to residents on 3/21/2017 by the Business Office Manager. The new Business Office Manager, who started in February 2017, was trained by the facility Administrator and outgoing Business Office Manager on policy and procedures, to include the Resident Trust Fund. Training was conducted from February 9, 2017 to 3/21/17. The facility Administrator will conduct audits of discharged residents who have a Resident Trust Fund weekly for four (4) weeks, then monthly for three (3) months to ensure any trust fund money is conveyed to the resident, responsible party or estate. The plan of correction action(s) will be monitored at the QAPI meeting for a minimum of four (4) months. Audit results will be taken to monthly QAPI meetings by the Business Office Manager.	

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2. Resident #38 was initially admitted to the facility on 7/18/13 and readmitted to the facility on 10/10/16. A review of the medical record indicated Resident #38 expired on 10/18/16.

A review of Resident #38's personal fund account statement indicated she had a balance of $39.35 at the time of her death on 10/18/16. On 2/21/17 a check was written in the amount of $39.35 to Resident #38's RP. This was 127 days after Resident #38's date of death.

An interview was conducted with the Administrator on 3/1/17 at 2:37 PM. She stated the facility had been without a BOM since she began her position as the Administrator at the facility on 8/31/16. The Administrator indicated she and the Human Resources Manager had been sharing the duties of the BOM.

A second interview was conducted with the Administrator on 3/1/17 at 3:40 PM. She indicated her expectation was for the conveyance of personal fund account balances to be completed within 30 days of the resident's date of death. She reported the facility had a PRN staff member assisting with the conveyance of personal funds.

An interview was conducted with PRN Administrative Staff #1 on 3/1/17 at 5:35 PM. She indicated she worked about 6-8 hours per week at the facility assisting with business office tasks. She stated she began this PRN work sometime in September of 2016. She indicated her job duties included the conveyance of personal fund account balances for residents expired. She reported she conveyed the personal

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fund account balances to the Clerk of Courts within 30 days of the resident's date of death.

The interview with PRN Administrative Staff #1 continued on 3/1/17 at 5:39 PM. Resident #38's date of death (10/18/16), the personal fund account statement with a balance of $39.35 on 10/18/16, and the $39.35 check dated 2/21/17 that was made out to Resident #38's RP were reviewed with PRN Administrative Staff #1. She revealed this conveyance of funds was late. She also revealed she conveyed the funds to Resident #38's RP rather than to the Clerk of Courts. She indicated she should have conveyed the funds to Clerk of Courts within 30 days of Resident #38's date of death.

3. Resident #129 was admitted to the facility on 3/8/15. A review of the medical record indicated Resident #129 expired on 9/29/16.

A review of Resident #129's personal fund account statement indicated she had a balance of $1,028.76 at the time of her death on 9/29/16. On 10/18/16 a payment of $1,028.76 was deducted from Resident #129's account for Patient Liability. This deduction depleted Resident #129's account.

An interview was conducted with the Administrator on 3/1/17 at 2:37 PM. She stated the facility had been without a BOM since she began her position as the Administrator at the facility on 8/31/16. The Administrator indicated she and the Human Resources Manager had been sharing the duties of the BOM.

A second interview was conducted with the

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Administrator on 3/1/17 at 3:40 PM. She indicated her expectation was for the conveyance of personal fund account balances to be completed within 30 days of the resident's date of death. She reported the facility had a PRN staff member assisting with the conveyance of personal funds.

An interview was conducted with PRN Administrative Staff #1 on 3/1/17 at 5:35 PM. She indicated she worked about 6-8 hours per week at the facility assisting with business office tasks. She stated she began this PRN work sometime in September of 2016. She indicated her job duties included the conveyance of personal fund account balances for residents expired. She reported she conveyed the personal fund account balances to the Clerk of Courts within 30 days of the resident's date of death.

The interview with PRN Administrative Staff #1 continued on 3/1/17 at 5:40 PM. Resident #129's date of death (9/29/16), the personal fund account statement with a balance of $1,028.76 on 9/29/16, and the 10/18/16 $1,028.76 deduction for Patient Liability from Resident #129's account were reviewed with PRN Administrative Staff #1. She indicated there were occasions when the resident's family requested that the Patient Liability payment was deducted from the account balance prior to the conveyance of funds. She revealed she was aware that no deductions were supposed to be made for Patient Liability after a resident had died. She also revealed the balance should have conveyed to the Clerk of Courts within 30 days of Resident #129's date of death.

4. Resident #75 was admitted to the facility on 10/17/16. A review of the medical record

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indicated Resident #75 expired on 12/13/16.

A review of Resident #75's personal fund account statement indicated he had a balance of $3.00 at the time of his death on 12/13/16. On 1/17/17 a payment of $3.00 was deducted from Resident #75's account for Patient Liability. This deduction depleted Resident #75's account.

An interview was conducted with the Administrator on 3/1/17 at 2:37 PM. She stated the facility had been without a BOM since she began her position as the Administrator at the facility on 8/31/16. The Administrator indicated she and the Human Resources Manager had been sharing the duties of the BOM.

A second interview was conducted with the Administrator on 3/1/17 at 3:40 PM. She indicated her expectation was for the conveyance of personal fund account balances to be completed within 30 days of the resident's date of death. She reported the facility had a PRN staff member assisting with the conveyance of personal funds.

An interview was conducted with PRN Administrative Staff #1 on 3/1/17 at 5:35 PM. She indicated she worked about 6-8 hours per week at the facility assisting with business office tasks. She stated she began this PRN work sometime in September of 2016. She indicated her job duties included the conveyance of personal fund account balances for residents expired. She reported she conveyed the personal fund account balances to the Clerk of Courts within 30 days of the resident's date of death.

The interview with PRN Administrative Staff #1

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F 160	Continued From page 14 continued on 3/1/17 at 5:41 PM. Resident #75's date of death (12/13/16), the personal fund account statement with a balance of $3.00 on 12/13/16, and the 1/17/17 $3.00 deduction for Patient Liability from Resident #75's account were reviewed with PRN Administrative Staff #1. She indicated there were occasions when the resident's family requested that the Patient Liability payment was deducted from the account balance prior to the conveyance of funds. She revealed she was aware that no deductions were supposed to be made for Patient Liability after a resident had died. She also revealed the balance should have conveyed to the Clerk of Courts within 30 days of Resident #75's date of death.	F 160		
F 166 SS=D	483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file	F 166		4/14/17

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grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;

(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;

(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;

(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;

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F 166	Continued From page 16 (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interview, the facility failed to follow their grievance policy by not notifying the person filing the grievance of the result of the investigation and the resolution to the grievance and by not investigating and resolving the grievance filed for 2 (Residents #72 & # 26) of 2 sampled residents reviewed for grievances. Findings included: The facility's grievance policy dated 12/30/16 was reviewed. The policy read in part "grievances may be made verbally to a staff member who will	F 166	F166 Resolve Grievances A grievance form was filled out for resident #72 on 2/2/17 by the Social Worker. The grievance for resident #72 was investigated 2/3/17-2/8/17 by Director of Nursing. Resolution was determined on 2/8/17 by DON. DON, notified the resident of the resolution on 2/8/17 at 2:40pm as validated by DON on 3/28/2017. A grievance form for Resident # 26 was	

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F 166	Continued From page 17 then complete the grievance form. All grievance forms are to be forwarded to the Social Worker Coordinator (SWC). The SWC will review and log the grievance. The form will be brought to the morning meeting for review. The grievance form will then be given to the department head responsible for that area. The grievance will be investigated and resolution achieved. Resolution is to be documented on the grievance form. Upon resolution, the grievance form will be returned to the SWC. Grievances must be resolved within 5 working days of the date the report is filed." 1. Resident # 72 was admitted to the facility on 86/16 with multiple diagnoses including Spondylosis with myelopathy (degenerative joint disease) cervical region. The quarterly Minimum Data Set (MDS) assessment dated 1/14/17 indicated that Resident # 72 had moderate cognitive impairment. On 2/27/17 at 12 Noon, Resident # 72 was interviewed. She stated that she had concerns with the staff not administering her medications on time especially her pain medication. On 2/27/17 at 3:15 PM, Resident # 72 was again interviewed. She claimed that she had concerns with the staff not passing her medications on time especially her pain medication. She added that she had brought this concerns to the staff but nothing had been done about it. Resident # 72 also shared that she had a concern with a staff member. She had called for a pain medication because she was hurting. The night nurse came in and put the medication on top of the over the	F 166	completed on 2/6/17 by the former Social Worker. It was investigated and corrective action completed on 2/6/17. The Director of Nursing notified resident #26□s son on 4/4/17 of the action taken. The son confirmed this was addressed and he was previously notified in February 2017. The January grievance log for Resident #72□s Notification of results section was completed by the Administrator in February 2017. Grievance Policy was revised to reflect: 1) Written grievance decisions include the date the grievance was received, a summary statement of the residents□ grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the residents concern(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility because of the grievance, and the date the written decision was issued. 2) The person filing the grievance, resident and/or resident□s representative will be informed of the resolution by the Social Services Director or Administrator. 3) A new grievance log was developed and implemented in February 2017. An in-service for all staff, including prn and weekend staff, regarding grievance process will be done by 4/14/2017. The in-services will be presented by the Social Worker and/or Administrator. The Social Services Director and/or	

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F 166	Continued From page 18 bed table. The medication was out of her reach. She called again and the same nurse came in. She told the nurse that she could not reach the medication. The nurse placed the medication on resident's chest and left the room. Resident # 72 was unable to remember the exact date of the incident or the name of the nurse but she indicated that she had reported the nurse. The grievance log was reviewed. The January 2017 grievance log listed Resident # 72's name. The log revealed that Resident # 72 had filed a grievance on 1/2/17. The grievance/complaint was "concerns with staff". The resolution and the date resolved were blank. The February 2017 grievance log listed Resident # 72's name. The log revealed that Resident # 72 had filed a grievance on 2/2/17. The grievance/complaint was"nursing". The log indicated that the grievance was resolved on 2/8/17. The grievance form dated 2/2/17 indicated that Resident #72 had filed a grievance regarding a staff member. The grievance was investigated and corrective action was completed on 2/8/17. At the bottom of the form, there was a statement "person making grievance has been notified of result, yes or no and the date, time and name of person notified." This statement was not answered. On 3/1/17 at 10:25 AM, the Director of Nursing (DON) was interviewed. The DON stated that if the resident's name was listed on the January 2017 grievance log there should have been a grievance form but the form could not be found so there was no investigation completed and no	F 166	Administrator will audit all grievances weekly for four (4) weeks then monthly for 3 months. All grievances will be reviewed for completion of investigation, resolution made and documented and for notification of resolution to the person filing the grievance. The Social Services Director will take audit results to the monthly QAPI meetings for a minimum of four (4) months. After the fourth month, the QAPI Committee will determine if resolution of the problem has occurred or if it needs to continue.	

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resolution made. The DON also indicated that she had investigated the grievance filed by Resident # 72 in February 2017 and after the investigation, the form was forwarded to the SWC who would then notify the person filing the grievance of the result of the investigation and the corrective action. The DON reviewed the grievance form dated 2/2/17 and acknowledged that the person who filed the grievance was not notified of the result of the investigation and the corrective action. The DON stated that the SWC was no longer employed at the facility.

SWC was not available for interview.
2. Resident #26 was admitted to the facility 1/26/17 and discharged to the hospital on 2/13/17. Cumulative diagnoses included: squamous cell carcinoma of the ear, chronic pain syndrome and liver transplant.

A physician's order dated 1/31/17 revealed an order for Erivedge (medication to treat squamous cell carcinoma) 150 milligrams by mouth daily. Do not send-family to provide.

An Admission Minimum Data Set dated 2/1/17 indicated Resident #26 was moderately impaired in cognition.

A review of the February Medication Administration Record (MAR) revealed there was no documentation that Resident #26 received Erivedge on 2/1/17, 2/2/17, 2/11/17 and 2/12/17.

On 3/1/17 at 9:36AM, a telephone interview was conducted with Resident #26's family member. He stated the medication for Resident #26 was taken to the facility on 1/26/17. At that time, the family member informed one of the nurses that

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Resident #26 needed to take that medication because it was the only medication that could help him and how important it was for him to receive it. The family member stated he checked on 1/31/17 to make sure Resident #26 was getting the medicine and it wasn't on the MAR. The family member said he spoke to the Director of Nursing on 1/31/17 and was informed the facility needed an order to administer the medication. She informed the family member they would obtain an order and she reassured him that Resident #26 would get his medication with no further problem. The family member stated he checked the MAR on 2/3/17 and noted that Resident #36 had only received Erivedge one time since 1/31/17. On 2/6/17, he said he called the facility and asked for the director of the facility. He spoke to the social worker at that time and explained the situation to her. He said he asked the social worker to file a grievance for him and understood that she would file the grievance at that time. He stated he never heard from the facility as to a resolution to his concern.

A review of the grievances for January and February 2017 revealed no grievances were filed on behalf or by Resident #26.

The social worker who was at the facility on 2/6/17 was no longer at the facility.

On 3/2/17 at 10:25AM, an interview was conducted with the Director of Nursing. She stated, per the grievance policy, a grievance would be filled out by the staff member who took the complaint. If the problem was fixed immediately, there would not be a grievance file. However, if someone asked that a grievance be filled out, one would be filled out at the time the

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F 166	Continued From page 21 concern was voiced. The grievance is turned in to the social worker who logs it in the grievance log and it would be given to the appropriate department head to address and handle. She said the facility had 5 days to investigate the grievance. There was a section at the bottom to document the date and time the person filing the grievance was notified. The Director of Nursing stated the grievances she had written had been obtained verbally or by phone. After the investigation had been completed, the grievance was given back to the social worker who would inform the resident/ responsible party/ family of the resolution and document when she informed them on the bottom of the grievance form. The Director of Nursing stated Resident #26's family member came to her directly regarding the Erivedge. She said she asked the family member who ordered the medication and was informed it was an oncologist. The family member told her he obtained the medication from the pharmaceutical company. She stated she told him the medication would not be covered by insurance and the family member stated it was provided by the family and was already in the building locked in the medication cart. She obtained a physician's order on 1/31/17 and notified the family member the order had been obtained and Resident #26 would receive the medication. The Director of Nursing said she filled out a grievance for Resident #26 on 1/31/17 and did not know why it was not on the grievance log or in the grievance book.	F 166		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must-	F 225		4/14/17

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F 225	Continued From page 22 (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to	F 225		

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F 225	Continued From page 23 the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility hired an employee who had a substantiated allegation of neglect of a resident on the Nursing Assistant Registry, which resulted in an employee with substantiated-neglect behavior provided direct care to the residents for 1 of 1 Nursing Assistant (Nursing Assistant #2) and the facility failed to report an injury of unknown source to Health Care Personnel Investigations which resulted in facility reporting non-compliance for 1 of 1 sampled resident (Resident #36). Findings included: 1. A review of the Nurse's Aide (NA) Registry search results document from the facility's	F 225	F225 Investigate/Report Allegations The Nurse Aide Registry cleared NA #2 on 1/25/2017. Re-verification of NA#2 certification. Nurse Aide Registry returned clearance of allegations of alleged abuse. The Staff Development Coordinator conducted an audit on all currently employed Nursing Assistants with the Nurse Aide Registry on 2/25/17 to re-verify none had a finding. There were no negative findings. Resident #36 injury of unknown origin was reported via the 24-hour report to the Health Care Personnel Investigation office	

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KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

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F 225	Continued From page 24 Human Resources revealed NA #2 had 1 substantiated finding of neglect of a resident, which occurred while she was employed in a nursing facility. The information was entered on the Registry on 10/8/15. On 3/1/17 at 11:00 am, an interview was conducted with the Health Care Personnel Registry Supervisor (Supervisor). The Supervisor stated she was familiar with NA #2. NA #2 had a substantiated allegation of neglect of a resident on 10/8/15 and was on the NA Registry when she was hired at the facility on 11/22/2016. NA #2 had requested to have her neglect charge removed from the NA Registry on 10/13/16, but the removal was not approved until 1/25/17. There was a 90-day-period from the time a request for registry removal was made to the time of an actual removal. On 3/2/17 at 11:15 am, an interview was conducted with the Business Officer (BO). The BO stated she retrieved all the NA Registry records for the NA applications and provided them to the Director of Nursing during the hiring process. On 3/2/17 at 9:40 am, an interview was conducted with the Director of Nursing (DON). The DON stated she was responsible for hiring and screening of all NAs, including NA #2. The NA Registry information obtained for potential hires was retrieved by the BO at the time of interview. All background check information was only provided to the Administrator. The Administrator provided information to the DON regarding whether there were issues with the background check.	F 225	by the Administrator on 3/24/17. An investigation was conducted by Director of Nursing and the Administrator and the 5-day report was completed and faxed in on 3/28/17. This was placed on the March Allegation of Abuse log. The facility Administrator and/or the Social Services Director are responsible for reporting allegations of abuse/neglect to HCPR. The facility initiated a new hire process on 3/27/2017. The Administrator will review all applicants background summary and results of the Nurse Aide Registry search prior to orientation. The Human Resources Director will perform all background checks and Nurse Aide Registry searches. The Human Resources Director will complete a check list of all completed paper work for applicants, to include the background check. The HR Director was educated on responsibilities as described by the Administrative Consultant and the facility Administrator on 3/22/17. In-service was done on 3/2/2017 by the Director of Nursing Services and the Administrator with direct care staff, including prn and weekend staff, addressing unusual occurrences that require reporting including appropriate time frame. An Allegation of Abuse Reporting Log has been developed to track timely compliance of allegations of abuse. The	

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F 225	Continued From page 25 An Interview was conducted on 3/3/17 at 11:24 am with the Administrator regarding the processing and screening of new hires. The Administrator stated that she reviewed the background checks of all applicants, which included the NA Registry. NA #2's NA registry results were overlooked. NA #2 was currently off the NA Registry, but NA #2 was still on the NA Registry at time of hire on 11/22/2016. 2. An interview was conducted on 3/3/17 at 9:19 am via telephone with Physician #1 about his communication with facility staff for Resident #36's orders after the incident. Physician #1 stated that he spoke to the nurse 2/7/17 about mid-day and provided orders for constipation and KUB (an abdominal x-ray that included kidneys, ureters, and bladder), and stated that he had concerns, to rule out abuse and make sure an investigation was performed. An interview was conducted on 3/1/17 at 3:47 pm with the facility Administrator. The Administrator was made aware of the cloth in Resident #36's rectum by NA #3 on 2/7/17 at 9:30 am. The DON was aware of the incident 1/6/17 at about 5:30 pm, but had not informed the Administrator. The Administrator, Staff Development Coordinator, and DON discussed the incident. The Administrator stated she directed Nurse #1 to obtain a statement from all who were involved. Statements were obtained from Nurse #1 and DON. Physician was notified on 2/10/17. The Administrator stated she expected staff to report incidences to her immediately. The Administrator stated that she did not consider the incident abuse, and the 24 hour and 5 day reports were not completed. The Administrator stated	F 225	log will be maintained by the Administrator and/or the Social Services Director. The Business Office Manager will complete an audit of all applicants scheduled for orientation weekly for eight (8) weeks to verify applicant does not have a finding entered in the State Nurse Aide Registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property. The facility Administrator will send the Allegation of Abuse Reporting Log to the Corporate Consultant for the next 5 occurrences to verify appropriate reporting time frames. This will be sent to the Corporate Consultant at the same time the 5 day is sent to the Health Care Personnel Investigation Office. All audits regarding Nurse Aide Registry checks will be taken to the monthly QAPI meetings by the HR Director. Abuse logs will be taken to the monthly QAPI meetings by the Administrator. This plan of correction will be monitored at the monthly QAPI until resolved.	

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F 225	Continued From page 26 that corporate office completed an investigation. An interview was conducted on 3/1/17 at 4:03 pm with the Corporate Consultant (CC). The CC was present at the facility to provide assistance with policies and procedures. The CC stated she heard about the incident from the DON and Administrator. The CC stated she was aware the incident happened on 2/6/17 and that the Administrator was not notified until 2/7/17. The CC stated she conducted interviews with Nurse #1 and NA #1. The CC stated that the incident had not appeared as a concern of abuse based on the interviews. An interview was conducted on 3/3/17 at 9:19 am via telephone with Physician #1 about his communication with facility staff for Resident #36's orders after the incident. Physician #1 stated that he spoke to the nurse 2/7/17 about mid-day and provided orders for constipation and KUB (an abdominal x-ray that included kidneys, ureters, and bladder), and stated that he had concerns, to rule out abuse and make sure an investigation was performed. Physician #1 stated he believed the cloth was placed in the rectum, possibly during dis-impaction, which was unusual.	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,	F 226		4/14/17

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F 226	Continued From page 27 (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on record review, physician interview, and staff interviews, the facility failed to screen a potential new hire which resulted in a Nursing Assistant hired with a substantiated allegation of neglect of a resident on the Nursing Assistant Registry for 1 out of 1 Nursing Assistant (Nursing Assistant #2) and failed to follow the policy for reporting an allegation of abuse to the Health Care Personnel Investigations which resulted in facility reporting non-compliance for 1 out of 1 resident (Resident #36). Findings included: A review of the facility's administrative policy and	F 226	F226 Abuse/Neglect Policies The Nurse Aide Registry cleared NA #2 on 1/25/2017. Re-verification of NA#2 certification. Nurse Aide Registry returned clearance of allegations of alleged abuse. The Staff Development Coordinator conducted an audit on all currently employed Nursing Assistants with the Nurse Aide Registry on 2/25/17 to re-verify none had a finding. There were no negative findings.	

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F 226	Continued From page 28 procedures for abuse reporting and investigations dated 3/11/2004 revealed: "Procedure: The facility will complete a thorough investigation of an alleged incident by the appropriate staff. The Administrator or designee will provide notice to the corporate staff and all appropriate state and regulatory agencies. The Director of Nursing or designee will initiate the investigation along with notifying the Department of Health and Human Service." A review of the facility ' s administrative policies and procedures employment screening section dated 3/11/2004 revealed: "A verification of the current license or certification status, including the Nurse ' s Aide registry, will be obtained to include whether any disciplinary action has been taken against them." 1. An interview was conducted on 3/3/17 at 9:19 am via telephone with Physician #1 about his communication with facility staff for Resident #36's orders after the incident. Physician #1 stated he spoke to the nurse 2/7/17 and provided orders for constipation and KUB, and stated that he had concerns, to rule out abuse and make sure an investigation was performed. On 3/1/17 at 12:10 pm Nurse #1 stated that she called Physician #1 (could not remember the date) and he ordered a KUB, Miralax, and Fleets and to r/o abuse. Nurse #1 could not recall when she informed the Administrator about the orders, but remembered she informed someone. An interview was conducted on 3/1/17 at 3:47 pm with the facility Administrator. The Administrator stated she was made aware of the cloth in Resident 36 ' s rectum by NA #3 on 2/7/17 at 9:30 am. The DON was aware of the incident 1/6/17 at about 5:30 pm, but had not informed the Administrator. The Administrator, Staff	F 226	Resident #36 injury of unknown origin was reported via the 24-hour report to the Health Care Personnel Investigation office by the Administrator on 3/24/17. An investigation was conducted by Director of Nursing and the Administrator and the 5-day report was completed and faxed in on 3/28/17. This was placed on the March Allegation of Abuse log. The facility Administrator and/or the Social Services Director are responsible for reporting allegations of abuse/neglect to HCPR. The facility initiated a new hire process on 3/27/2017. The Administrator will review all applicants background summary and results of the Nurse Aide Registry search prior to orientation. The Human Resources Director will perform all background checks and Nurse Aide Registry searches. The Human Resources Director will complete a check list of all completed paper work for applicants, to include the background check. The HR Director was educated on responsibilities as described by the Administrative Consultant and the facility Administrator on 3/22/17. An in-service was conducted 3/2/17 by the Director of Nursing Services and the Administrator with all direct care staff, including prn and weekend staff, addressing unusual occurrences that require reporting including appropriate time frame.	

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F 226	Continued From page 29 Development Coordinator, and DON discussed the incident. The Administrator stated she directed Nurse #1 to obtain a statement from all who were involved. Statements were obtained from Nurse #1 and the DON. The Administrator stated she expected staff to report incidences to her immediately. The Administrator stated that she did not consider the incident abuse, and the 24 hour and 5 day reports were not completed. The Administrator stated that corporate office completed an investigation. An interview was conducted on 3/1/17 at 4:03 pm with the Corporate Consultant (CC). The CC was present at the facility to provide assistance with policies and procedures. The CC stated she heard about the incident from the DON and Administrator. The CC stated she was aware the incident happened on 2/6/17 and that the Administrator was not notified until 2/7/17. The CC stated she conducted interviews with Nurse #1 and NA #1. The CC stated that the incident had not appeared as a concern of abuse based on the interviews. 2. A review of the Nurse's Aide (NA) Registry search results document from the facility ' s Human Resources revealed NA #2 had 1 substantiated finding of neglect of a resident, which occurred while she was employed in a nursing facility. The information was entered on the Registry on 10/8/15. On 3/1/17 at 11:00 am an interview was conducted with the Health Care Personnel Registry Supervisor (Supervisor). The Supervisor stated she was familiar with NA #2. NA #2 had a substantiated allegation of neglect of a resident on 10/8/15 and was on the NA Registry when she was hired at the facility on 11/22/2016. NA #2 had requested to have her neglect charge	F 226	An Allegation of Abuse Reporting Log has been developed to track timely compliance of allegations of abuse. The log will be maintained by the Administrator and/or the Social Services Director. The Business Office Manager will complete an audit of all applicants scheduled for orientation weekly for eight (8) weeks to verify applicant does not have a finding entered in the State Nurse Aide Registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property. The facility Administrator will send the Allegation of Abuse Reporting Log to the Corporate Consultant for the next 5 occurrences to verify appropriate reporting time frames. This will be sent to the Corporate Consultant at the same time the 5 day is sent to the Health Care Personnel Investigation Office. All audits regarding Nurse Aide Registry checks will be taken to the monthly QAPI meetings by the HR Director. Abuse logs will be taken to the monthly QAPI meetings by the Administrator. This plan of correction will be monitored at the monthly QAPI until resolved.	

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F 226	Continued From page 30 removed from the NA Registry on 10/13/16, but the removal was not approved until 1/25/17. There was a 90-day-period from the time a request for registry removal was made to the time of an actual removal. On 3/2/17 at 11:15 am an interview was conducted with the Business Officer (BO). The BO stated she retrieved all the NA Registry records for the NA applications and provided them to the Director of Nursing during the hiring process. On 3/2/17 at 9:40 am an interview was conducted with the Director of Nursing (DON). The DON stated she was responsible for hiring and screening of all NAs, including NA #2. The NA Registry information obtained for potential hires was retrieved by the BO at the time of interview. All background check information was only provided to the Administrator. The Administrator provided information to the DON regarding whether there were issues with the background check. An Interview was conducted on 3/3/17 at 11:24 am with the Administrator regarding the processing and screening of new hires. The Administrator stated that she reviewed the background checks of all applicants, which included the NA Registry. NA #2 ' s NA registry results were overlooked. NA #2 was currently off the NA Registry, but NA #2 was still on the NA Registry at time of hire on 11/22/2016."	F 226		
F 257 SS=E	483.10(i)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS (i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81 degrees F.	F 257		4/14/17

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F 257	Continued From page 31 This REQUIREMENT is not met as evidenced by: Based on observation of room air temperatures, resident interview, family interview, and staff interview the facility failed to address an identified ongoing problem with the maintenance of comfortable room air temperatures in resident rooms resulting in the residents remaining in the common area during the hours when they were awake to avoid the cold air temperature inside of their room for 2 of 2 residents (Residents #7 and #8) reviewed for safe and comfortable temperatures. The findings included: 1. Resident #8 was initially admitted to the facility on 8/14/13 and readmitted on 12/16/13 with multiple diagnoses that included heart failure and dementia. The annual Minimum Data Set (MDS) 11/23/16 indicated Resident #8 had moderate cognitive impairment. Record review indicated Resident #8 resided in room 418 through 12/13/16. On 12/13/16 she moved to room 412. An interview was conducted with Resident #8 on 2/27/17 at 10:27 AM. Resident #8 was seated in a common area of the 400 unit. She stated she had not wanted to go into her room for the interview because it was cold in her room. She indicated she avoided her room during the hours when she was awake because her room was cold. She reported she stayed in the common area of the 400 unit because it was warmer there. Resident #8 stated she "told the [Maintenance Director] and he said he couldn' t fix it". She indicated she had resided at the facility for over 2	F 257	F257 Temperature Levels Ambient room temperatures are being checked on the 400 hall every morning by the maintenance staff. Resident #7 and #8 rooms are on the 400 hall. The maintenance director replaced the heat strips in the air handler for 400 hall on March 18th, 2017. Extra blankets were available for residents, including #7 and #8 until the heat strips were received and replaced. Once the heat strips were in place, the 400 hall room temperatures have been in a 71-81-degree range. The Maintenance Director was in-serviced by the Administrator and the Nurse Consultant on 3/6/2017 regarding ambient air temperatures in the facility. Maintenance Director initiated a random daily temperature audit, and a daily morning audit for rooms on the 400 hall. Inside and Outside heating and air units are checked randomly every week while ensuring all units are checked monthly. If the ambient temperature is not within acceptable parameters (71-81 degrees), the thermostats are adjusted accordingly by the Maintenance Department. On 3/9/2017, Wilheim's Heating and Air replaced the compressor and re-wired the condenser. Maintenance Director will continue random Monday through Friday 4 times a day temperature audits thorough 3/31/2017 to ensure comfortable and safe temperatures. 1. How the corrective action(s) will be	

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F 257	Continued From page 32 years and her room had continued to be cold throughout her stay. Resident #8 reported she had a room change a few months ago. She indicated her current room (412) and her old room (418) were both uncomfortably cold. An interview was conducted with Nursing Assistant (NA) #6 on 2/27/17 at 11:38 AM. She indicated she had worked at the facility for 13 years. She stated the 2 rooms on each corner of the 400 unit tended to be cold (Rooms 409 through 412 and 415 through 418). She indicated the residents that resided in those rooms spent most of their time in the common area when they were awake due to their rooms being cold. NA #6 revealed this had been an ongoing problem for years. She additionally revealed the Maintenance Director was aware of the problem, but nothing had been done to improve it. An interview was conducted with Nurse #3 on 3/2/17 at 8:10 AM. She indicated the rooms on each corner of the 400 unit tended to be cold (Rooms 409 through 412 and 415 through 418). Nurse #3 reported the residents were encouraged to keep the doors to their rooms open so the heat from the common area could warm up their rooms. She stated Resident #8 had complained about her room being cold as she resided in one of the corner rooms. Nurse #3 revealed this was an ongoing problem. She additionally revealed the Maintenance Director was aware of the issue, but he indicated it was unable to be fixed. An interview was conducted with the Maintenance Director on 3/2/17 at 8:15 AM. He stated he began working at the facility in June of 2016 as the Maintenance Assistant. He indicated he took over as Maintenance Director sometime between	F 257	monitored to ensure the practice will not recur: a. Maintenance Director will continue to conduct random audits of ambient air temperatures weekly times one month and with any significant change in weather temperature from 4/1/2017- 4/30/2017 for all areas to include rooms 409-412 and 415-418. b. Maintenance Supervisor will conduct monthly inspections of affected units monthly x three (3). Results of Ambient Air Temperature log will be brought to the QAPI committee monthly by the Maintenance Director for review until compliance has been achieved as determined by the Committee. Finding of the April temperature audit will be discussed at the Resident Council in May.	

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August and October. He reported there were 8 rooms in the 400 unit that were on the ends of the building and tended to be colder than the rest of the facility. He stated these rooms were 409 through 412 and 415 through 418. He indicated this included Resident #8's room. The Maintenance Director stated that because of the way the facility was built and the insulation within the facility, these corner rooms were cooler than the other rooms. He reported the thermostat was centralized and there were no individual thermostats for each room.

An observation was conducted of the Maintenance Director on 3/2/17 at 8:20 AM utilizing a thermometer sensor with a laser to obtain the air temperature inside of Resident #8's room. The thermometer sensor revealed Resident #8's room air temperature was 66 degrees Fahrenheit (F).

The interview with the Maintenance Director continued on 3/2/17 at 8:22 AM. He indicated sometimes the staff or a resident complained to him of a room being cold. He reported that he turned up the temperature on the central thermostat when he received a complaint. He stated he had not logged the air temperature of a room if a complaint was reported. He also stated he had not conducted any monitoring of the room air temperatures. The Maintenance Director revealed he was unaware of what the air temperature inside the facility was supposed to be. He stated he had minimal training provided to him when he took over as the Maintenance Director.

An interview was conducted with the Administrator on 3/2/17 at 8:30 AM. She

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indicated she expected the air temperatures within the facility to be comfortable for the residents. She stated she was aware the rooms on the corners of the 400 unit tended to be cooler, but she was not aware of the actual air temperatures in those rooms.

2. Resident #7 was admitted to the facility on 6/27/11 and readmitted on 5/8/15 with multiple diagnoses that included Alzheimer's.

Record review indicated Resident #7 resided in room 418.

The quarterly MDS assessment dated 1/25/17 indicated Resident #7 was rarely/never understood, she had short term memory problems, and long term memory problems.

An interview was conducted with NA #6 on 2/27/17 at 11:38 AM. She indicated she had worked at the facility for 13 years. She stated the 2 rooms on each corner of the 400 unit tended to be cold (Rooms 409 through 412 and 415 through 418). She indicated the residents that resided in those rooms spent most of their time in the common area when they were awake due to their rooms being cold. NA #6 revealed this had been an ongoing problem for years. She additionally revealed the Maintenance Director was aware of the problem, but nothing had been done to improve it.

A family interview was conducted for Resident #7 on 2/27/17 at 3:40 PM. Resident #7's family member indicated the resident rooms on the corners of the 400 unit were cold in the winter months. She reported Resident #7 had resided in one of the corner rooms.

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An interview was conducted with Nurse #3 on 3/2/17 at 8:10 AM. She indicated the rooms on each corner of the 400 unit tended to be cold (Rooms 409 through 412 and 415 through 418). Nurse #3 reported the residents were encouraged to keep the doors to their rooms open so the heat from the common area could warm up their rooms. Nurse #3 revealed this was an ongoing problem. She additionally revealed the Maintenance Director was aware of the issue, but he indicated it was unable to be fixed.

An interview was conducted with the Maintenance Director on 3/2/17 at 8:15 AM. He stated he began working at the facility in June of 2016 as the Maintenance Assistant. He indicated he took over as Maintenance Director sometime between August and October. He reported there were 8 rooms in the 400 unit that were on the ends of the building and tended to be colder than the rest of the facility. He stated these rooms were 409 through 412 and 415 through 418. He indicated this included Resident #7's room. The Maintenance Director stated that because of the way the facility was built and the insulation within the facility, these corner rooms were cooler than the other rooms. He reported the thermostat was centralized and there were no individual thermostats for each room.

An observation was conducted of the Maintenance Director on 3/2/17 at 8:21 AM utilizing a thermometer sensor with a laser to obtain the air temperature inside of Resident #7's room. The thermometer sensor revealed Resident #7's room air temperature was 67 degrees F.

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F 257	Continued From page 36 The interview with the Maintenance Director continued on 3/2/17 at 8:22 AM. He indicated sometimes the staff or a resident complained to him of a room being cold. He reported that he turned up the temperature on the central thermostat when he received a complaint. He stated he had not logged the air temperature of a room if a complaint was reported. He also stated he had not conducted any monitoring of the room air temperatures. The Maintenance Director revealed he was unaware of what the air temperature inside the facility was supposed to be. He stated he had minimal training provided to him when he took over as the Maintenance Director. An interview was conducted with the Administrator on 3/2/17 at 8:30 AM. She indicated she expected the air temperatures within the facility to be comfortable for the residents. She stated she was aware the rooms on the corners of the 400 unit tended to be cooler, but she was not aware of the actual air temperatures in those rooms.	F 257		
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.	F 278		4/14/17

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F 278	Continued From page 37 (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 record review, observation and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of pressure ulcer for 1 (Resident #4) of 4 sampled residents reviewed for pressure ulcer and in the area of hospice for 2 (Residents # 86 & #81) of 2 sampled residents reviewed for hospice. Findings included: 1. Resident # 4 was originally admitted to the facility on 12/1/16 with multiple diagnoses including Dementia and unstageable pressure ulcer on left buttock. The admission Minimum Data Set (MDS) assessment dated 12/7/16	F 278	F278 Assessment Accuracy A new MDS Coordinator was hired on 2/20/2017. A new treatment nurse was hired on 1/19/2017. The MDS Coordinator will be in-serviced on assessment accuracy by the Nurse Consultant no later than 4/14/2017. The treatment nurse will be in-serviced on accurately coding Section M by the Nurse Consultant no later by 4/14/2017. A modification assessment was completed on 4/5/2017 by the treatment nurse for Resident #4 to add the dimensions of the identified pressure	

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F 278	Continued From page 38 indicated that Resident #4 ' s cognition was severely impaired and she had unstageable pressure ulcer that was present on admission. The "dimension of unhealed pressure ulcer" section of the assessment was not completed with width, length and depth of the pressure ulcer. Resident #4's pressure ulcer on the left buttock was assessed on admission (12/1/16). The assessment revealed a 7 centimeter (cm) (width) x (by) 6 cm (length) x 1.3 cm (depth). On 3/1/17 at 10:40 AM, Resident #4 was observed during the dressing change. The pressure ulcer on the left buttock was deep with eschar on the wound bed. On 3/2/17 at 10:45 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS assessments to be accurate. On 3/2/17 at 12:27 PM, the MDS Nurse was interviewed. The MDS Nurse stated that the Treatment Nurse was responsible for completing the pressure ulcer section. She indicated that if a resident has a pressure ulcer, the dimension section of the MDS assessment should be completed with the width, length and depth of the pressure ulcer. On 3/2/17 at 2:25 PM, the Treatment Nurse was interviewed. She stated that the Treatment Nurse who completed the admission MDS assessment of Resident #4 was no longer employed at the facility. The Treatment Nurse further indicated that she started as treatment nurse end of January 2017. The Treatment Nurse indicated that she was responsible for completing the	F 278	ulcer. A modified assessment was completed on 4/3/2017 for resident #86 by the MDS Coordinator to code terminal illness in prognosis section. A modification assessment was completed on 4/5/2017 by MDS Coordinator for resident #81 to correct the coding for hospice. A random audit will be completed on 10% of current residents to assess accuracy of the MDS by 4/13/17. Audit will be completed by Nurse Consultants. Moving forward, the treatment nurse will be responsible for completing section M of the MDSs. Prior to closing of any MDS, the MDS Coordinator and at least one Administrative Nurse will review Section M, J1400 and O0100 to ensure accuracy for a minimum of weekly for four weeks, twice a month for one month, then monthly for one month. The deficiency will be placed in the QAPI program for monitoring of resolution/correction. The compliance audits will be reviewed during the monthly QAPI meetings for three (3) months to assure compliance is sustained. The QAPI Committee will determine need to continue or resolve the problem. Audits will be brought to the QAPI Committee by the MDS Coordinator.	

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pressure ulcer section of the MDS assessments. She indicated that if a resident has a pressure ulcer, the dimension section should be completed with the width, length and depth of the pressure ulcer.

2. Resident # 86 was admitted to the facility on 3/26/15 with multiple diagnoses including Dementia and Diabetes Mellitus. The significant change in status Minimum Data Set (MDS) assessment dated 11/18/16 indicated that Resident #86 had memory and decision making problems and he had received hospice services while a resident at the facility. The prognosis section of the MDS assessment was coded "no" indicating that the resident did not have a condition or chronic condition with life expectancy of less than 6 months.

On 3/2/17 at 10:45 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS assessments to be accurate.

On 3/2/17 at 12:27 PM, the MDS Nurse was interviewed. The MDS Nurse stated that the MDS Nurse who completed the assessment of Resident #86 was no longer employed at the facility. She also indicated that the prognosis section of the MDS assessment should be coded "yes" if the resident was receiving hospice services.

3. Resident #81 was initially admitted to the facility on 6/29/11 and most recently readmitted on 7/23/16.

The quarterly Minimum Data Set (MDS) assessment dated 9/7/16 indicated Resident #81

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had moderate cognitive impairment. Section O, the Special Treatments, Procedures, and Programs section, indicated Resident #81 had received hospice care during the last 14 days while a resident at the facility (Question O0100K2).

A review of the medical record indicated Resident #81 was discharged from hospice care on 10/4/16.

The annual MDS assessment dated 12/6/16 indicated Resident #81 had moderate cognitive impairment. Section O, the Special Treatments, Procedures, and Programs section, indicated Resident #81 had received hospice care during the last 14 days while a resident at the facility (Question O0100K2).

An interview was conducted with the Director of Nursing on 3/2/17 at 10:40 AM. She indicated she expected the MDS to be coded accurately.

An interview was conducted with the MDS Coordinator on 3/2/17 at 12:18 PM. She stated she began working at the facility on 2/20/17. She indicated the previous MDS Coordinator no longer worked at the facility. Section O of the MDS dated 12/6/16 for Resident #81 that indicated he had received hospice care during the last 14 days while a resident at the facility (Question O0100K2) was reviewed with the MDS Coordinator. The medical record documentation that indicated Resident #81 was discharged from hospice care on 10/4/16 was reviewed with the MDS Coordinator. She stated she had not completed this MDS for Resident #81, but revealed it was inaccurate based on the medical record.

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F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279		4/14/17

483.20
(d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.

483.21
(b) Comprehensive Care Plans

(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not 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

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F 279	Continued From page 42 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interivew, the facility failed to develop a care plan for the use of antipsychotic and hypnotic medication for two of five residents reviewed for unnecessary medicaiton use (Resident #39 and #44. The findings included: 1. Resident #39 was admitted to the facility 8/15/15. Cumulative diagnoses included major depressive disorder, severe depression psychosis, unspecified psychosis and insomnia. A mental health note dated 8/19/16 stated Resident #39 reported a history of schizophrenia with over 10 inpatient hospitalizations. Resident #39 stated he was last hospitalized over one year ago and said he had feelings of depressed mood,	F 279	F279 Comprehensive Care Plans Care plans addressing the use of psychotropic medications for residents #39, #44 were developed 3/2/2017 by the MDS Coordinator. A care plan was developed for resident #39 addressing his insomnia and use of hypnotic medications on 3/2/2017 by the MDS Coordinator. The MDS Coordinator will be in-serviced by the Clinical Nurse Consultant on ensuring care plans are developed as indicated in the CAA and other identified areas of need by 4/13/2017. An audit was completed on 4/2/17 of the 62 residents receiving psychotropic/hypnotic medications to	

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F 279	Continued From page 43 anxiety, fatigue, hopelessness and helplessness. Resident #39 rated his depression as 9/10 with 10 being worse. Current psychotropic medications included: Geodon for psychosis, Prozac for depression/ anxiety, Elavil for depression/ insomnia, Ambien for insomnia and as needed Xanax for anxiety. A review of the physician orders for February 2017 revealed ordered medications included Geodon HCL (antipsychotic medication) 40 milligrams by mouth twice daily and Ambien FC (hypnotic medication) 5 milligrams by mouth every bedtime. A care plan dated 11/23/16 stated Resident #39 was currently taking psychotropic medications (antianxiety/ antidepressant) and was at risk for adverse reaction. Approaches included: Monitor and record any displayed behavior or mood problems. Encourage appropriate behavior; discourage inappropriate behavior. Monitor effectiveness of psychotropic meds. Monitor for involuntary movements and repetitive behaviors and report to the physician. Review medications every three months for possible dose reduction. Allow him to express feelings as needed. Encourage by mouth intake within dietary limits. Monitor for weight loss. Psychiatric consult as needed. There was no care plan for the use of antipsychotic medication or the use of hypnotic medication for insomnia. An Annual Minimum Data Set (MDS) dated 11/24/16 indicated resident #39 was cognitively intact. Mood was documented as having little interest and pleasure in doing things 7--11 days. No behaviors were noted. Medications administered during the look back period included	F 279	ensure that those residents had a corresponding care plan. 100% of those residents have a care plan in place. The MDS Coordinator has reviewed and updated/created care plans for all residents receiving psychotropic medications on 4/2/2017. Auditing of care plans for resident□s receiving psychotropic medications will be completed weekly for 2 weeks, then twice a month for one month, then monthly for four (4)) months by the Director of Nursing, Staff Development Coordinator and/or Nurse Consultant, to ensure a care plan addressing the use of psychotropic medications is in place. The QAPI Committee will review audit results for compliance monthly for six (6) months in the monthly QAPI meeting to assure compliance is sustained. Audit results will be brought to QAPI by the DON. Date of Compliance 4/14/17.	

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7 days of antipsychotic medication, antianxiety medication, antidepressant medication and hypnotic medication.

A Care Area Assessment (CAA) for psychosocial well-being dated 12/4/16 stated Resident #39 stayed in his room during the day and came out in the evening. He participated in evening activities. Direct staff tried to anticipate and meet all social issues. This would be care planned.

A CAA for psychotropic medications dated 12/4/16 stated Resident#39 was at risk for adverse effects associated with use of psychotropic medications, such as serious injury from falls. Psychiatric services were available to adjust medications and pharmacy was to review medications as needed. Behavior monitoring sheets were completed and abnormal behaviors reported to the physician. Medications were adjusted as needed and ordered per physician. This would be care planned.

On 2/28/2017 at 9:12AM, an interview was conducted with Resident #39. He stated he was doing fairly well with his medications. He said he had received Geodon prior to coming to the facility in 2015 and was aware they had decreased his dosage to 80 milligrams a day. Resident #39 said he still had episodes of feeling anxious and took Xanax as needed. He stated he had insomnia and the medication he was now taking helped him sleep.

On 3/2/17 at 12:19PM, an interview was conducted with MDS coordinator who stated she had assumed the position of MDS Coordinator on 2/20/17. She stated she was in the process of updating all of the care plans and stated Geodon

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was included in the psychotropic care plan and that care plan was not just for antidepressants and anti-anxiety medication. She said there should have been a care plan for the diagnosis of insomnia and the use of Ambien.

2. Resident #44 was admitted to the facility 6/3/16. Cumulative diagnoses included dementia without behavioral disturbance.

A Quarterly Minimum Data Set (MDS) dated 12/14/16 indicated Resident #44 was moderately impaired in cognition. No mood indicators were noted. Behavioral symptoms not directed towards others was noted as having occurred 1-3 days. Medication during the look back period included 7 days of antipsychotic medication.

A care plan dated 1/6/17 stated Resident #44 had aberrant behavior as evidenced by refusing showers. Approaches included monitoring behaviors and assessing for trends. Psychological evaluation if needed. Notify physician/ family of increased behaviors. Encourage compliance with activities of daily living (ADL's) daily. Medications as ordered. Explore with resident reason or reasons for non-compliance. There was not a care plan for the use of antipsychotic medication.

A physician's progress note dated 1/27/17 stated Resident #44 received Haldol for behavioral changes.

A review of physician orders for February 2017 revealed an order for Haldol (antipsychotic medication) 0.5 milligrams by mouth every night for behavioral changes.

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F 279	Continued From page 46 On 3/2/17 at 4:42PM, an interview was conducted with the MDS Coordinator who stated Resident #44 should have had a care plan for the use of Haldol. On 3/2/17 at 5:15 PM, an interview was conducted with the Director of Nursing who stated she would expect the Haldol to have been care planned.	F 279		
F 280 SS=D	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. (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	F 280		4/14/17

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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--

(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

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F 280	Continued From page 48 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 observation, record review and staff interview, the facility failed to review and revise the care plan for weight loss for one of three residents reviewed for nutrition who experienced a significant weight loss in 6 months (Resident #87). The findings included: Resident #87 was admitted to the facility 7/7/15. Cumulative diagnoses included dementia without behavioral disturbance and depression. A Quarterly Minimum Data Set (MDS) dated 12/13/16 indicated Resident #87 was severely impaired in cognition. She required supervision with eating. Weight documented during the assessment period was 121 pounds with no weight loss or gain. A care plan dated 7/6/16 and last reviewed 1/2/17 indicated Resident #87 was on a therapeutic diet. Additions to the problem dated 11/2/16 stated weight loss due to depression. One of the care plan goals specified that Resident #87 would not have significant weight loss. Approaches included diet as ordered. Offer equivalent substitute if needed. Monthly/ weekly weight as	F 280	F280 Planning Care/Revise Care Plan The weight loss care plan for resident #87 was reviewed and revised and updated by facility Registered Dietician 3/23/2017. Care plans of residents with significant weight changes will be audited by Divisional Registered Dietician/ Facility Dietician to ensure a care plan is present and that appropriate interventions and correct diet are included by 4/14/2017. In-service provided to Food Service Director and facility dietician by Divisional Registered Dietician on developing and updating revision of nutritional care plans on 3/23/2017. Resident #87 will be added to the Standard Of Care (SOC) meeting to be reviewed for weight changes. In-service to ALL dietary staff by Divisional Registered Dietician on 3/22/2017 regarding definition of fortified food, preparation and use of fortified foods. Regional Dietician and Facility Dietician completed a comparison of Meal Tracker	

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F 280	Continued From page 49 appropriate. Monitor percentage eaten and record. Encourage adequate intake and compliance. Dietary consult. Notify family/ physician of change of status. Monitor for signs and symptoms of dehydration. Interventions added on 12/28/16 was protein supplement three times daily for nutritional support and on 1/2/17 potassium rich foods. No further interventions for the management of the resident's continued weight loss was indicated on the care plan after 1/2/17. A review of weights from August 2016 through February 2017 revealed the following: 8/7/16-132 pounds; 9/28/16--125.4 pounds; 10/1/16--124.6 pounds; 11/5/16--122.8 pounds; 12/4/16--121.4 pounds; 1/1/17--118.2 pounds and 2/5/17--116.2 pounds. This represented a 11.97 percent a significant unplanned weight loss from 8/7/16 through 2/5/17 (previous 6 month period). Physician orders for February 2017 revealed a diet order for regular no added salt diet with potassium rich foods. House supplement powder (protein powder) in 8 ounces of water three times daily after eating (9:00AM, 1:00PM and 5:00PM) with the original physician order dated 7/24/15. Protein powder 1 scoop in 4 ounces of fluid three times daily for supplement (8:00AM, 12 noon and 4:00PM) with the original physician order dated 12/28/16. There was not a physician's order for super foods or for double portions. A Registered Dietician (RD) note dated 2/16/17 at 5:40PM stated Resident #87 was on a no added salt diet. She received protein powder 1 scoop three times daily and super foods. Intake was noted at 50-75% and she accepted bedtime	F 280	diets with those listed for residents to ensure proper diet was being served on 3/23/17. Care plans of residents with significant weight change will be audited weekly for 4 weeks, then 2 times a month for one month, then monthly for 2 months by facility Registered Dietician or Facility Food Service Director (CDM) to ensure a care plan is present with appropriate interventions. The Food Service Director and facility Registered Dietician will be responsible for all nutritional care plans. The facility Registered Dietician/ CDM will update care plans with all significant weight changes. Facility Food Service Director (CDM) will perform a nutritional assessment on all new admissions for nutritional needs during the first week of stay in the facility. The DON or Assistant Director of Nursing (ADON) will give the CDM a copy of all new diet orders daily Monday-Friday after morning clinical meeting. Weekend orders will be given to the CDM on Mondays. SOC team will review all residents with significant weight changes in SOC meetings weekly until weight is stable or resident has been deemed as “Unavoidable Weight loss” by physician. In-service will be presented to nursing direct care staff by the CDM regarding what fortified foods are and how they can monitor to ensure residents ordered fortified foods are receiving fortified foods at meals by 4/14/2017. The Facility Registered Dietician will be	

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F 280	Continued From page 50 snacks. Weight was documented at 116.2 pounds with a weight loss of 11.97% during the last 6 months. Potential for variance in weight might be due to hypothyroidism. The RD made no new recommendations to address Resident #87's continued weight loss. On 2/28/17 at 12:40PM, an observation was conducted during the lunch meal. Resident #87 was feeding herself and consumed 100% of the protein supplement and approximately 75 percent of a grilled cheese sandwich. Resident #87 had green beans and consumed very few bites. Resident #87's diet slip indicated her current diet was no added salt with super foods. On 3/1/17 at 10:10AM, an interview was conducted with Physician #2. She stated she usually received a list of weights monthly. If weight loss was noted, she would normally call the dietician for a referral, order Remeron (antidepressant) or Marinol (used for loss of appetite). Physician #2 said she would also order a house supplement--sometimes liquid, sometimes powder. She reviewed her notes and stated she had noted weight loss for Resident #87 on 2/14/17 but had not implemented anything. She said she must have just missed it. The physician stated she would order Marinol or Remeron to increase Resident #87's appetite and would order a house supplement to address the resident's continued weight loss. On 03/01/2017 at 10:28AM, an interview was conducted with the Registered Dietician. She stated Resident #87 received super foods and her intake averaged 50-75% when she reviewed the chart on 2/16/17. The RD stated she ordered protein powder 12/28/16 for added protein to help	F 280	notified of significant weight loss by the CDM as soon as she/he is aware. Audits will be performed by facility Registered Dietician or CDM on residents experiencing significant weight change weekly x 4, then bi- weekly for one month, then monthly for two months Audits will be performed by Facility Registered Dietician or CDM weekly x4, then twice monthly for one month, then monthly for 2 months on care plans correctly reviewed/revised for weight loss. The CDM will do an audit comparing the physician's order to meal tracker tickets weekly for 4 weeks, then twice a month for 1 month, then monthly for two months. The District Manager for Healthcare Services (dietary department) will perform an audit on 4/6/17 comparing meal ticket to meal served . Thereafter, the CDM will perform this audit weekly for four weeks then twice a month for one month, then monthly for two months. This deficiency will be placed in the QAPI program for monitoring by the QAPI Committee for a period of three (3) months. Audit results will be taken to the QAPI program by the Facility Registered Dietician or CDM.	

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F 280	Continued From page 51 with weight loss and to get extra protein in Resident #87. She reviewed the chart and indicated Resident #87's physician wrote the order for protein powder on 12/28/16 and was unaware that Resident #87 already had been receiving a protein powder supplement. The RD stated she had not recommended an intervention to address Resident #87's weight loss since her recommendation in December 2016. She reviewed the care plan and stated it should be revised due to the weight loss. On 3/02/2017 at 12:19PM, an interview was conducted with the MDS Coordinator. She stated she had assumed the position on 2/20/17. She said she was responsible for the care plans and was working on updating all of them. She had not had a chance to review all the care plans.	F 280		
F 281 SS=E	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record reviews, physician interview, and staff interviews, nursing staff failed to follow the physician's order for Levemir (insulin) and blood glucose monitoring for 1 of 1 sampled resident (Resident #1) reviewed, failed to follow the physician's order for Ativan (antianxiety medication) for 1 of sampled 5 residents (Resident #7) reviewed for unnecessary	F 281	F281 1. Immediate action(s) taken for the resident(s) found to have been affected include: a. Resident #1 insulin is being administered as ordered. Blood glucose is being obtained as ordered and sliding scale insulin provided as ordered based	4/7/17

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F 281	Continued From page 52 medications, and failed to follow the physician's orders for Remeron (antidepressant medication/appetite stimulant) and Resource (nutritional supplement) for 1 of 3 sampled residents (Resident #117) reviewed for nutrition. Findings included: 1. A review of nursing and the minimum data set records performed for Resident #1 revealed she was admitted on 9/28/16. The quarterly minimum data set assessment was on 1/5/17. The resident was assessed as cognitively impaired. The resident required extensive assistance for activities of daily living and had to be fed. The resident's diagnosis were anemia, hypertension, diabetes, hyperlipidemia, metabolic encephalopathy, gastro-esophageal reflux disease, malaise, chronic kidney disease, generalized weakness, and dysphagia. Review of Resident #1's medication administration records (MAR) revealed that there were three doses of Levemir 12 units subcutaneous (insulin) at bedtime not administered on 12/9/16, 12/13/16, and 12/15/16. The blood glucose (BG) was not monitored prior to administration of regular insulin sliding scale on 12/8/16. There was no blood glucose monitored on 12/22/16 through 12/25/16 at bedtime. The MAR revealed blood glucose levels were frequently elevated over 200. Review of physician's order dated 12/1/17 revealed orders for Levemir 12 units subcutaneous at bedtime; Regular Insulin sliding scale: BG 151-200 give 2 units, BG 201-250 give 3 units, BG 251-300 give 4 units, BG 301-350 give 6 units, BG 351-400 give 8 units, BG >400 give 10 units and call the physician; blood	F 281	on blood glucose. b. Physician and pharmacist will review blood glucose for Resident #1 to ensure current insulin orders and sliding scale coverage is adequate c. Resident #7 is receiving Ativan as ordered. Orders have been reviewed to ensure accuracy and correctness. d. The Medical Administration Record (MAR) for Resident #7 has been reviewed to ensure medication is administered as ordered. e. Resident #117 was discharged but has since been re-admitted to facility on 1/31/2017. f. All new orders will be reviewed in Morning Clinical Meeting. Applicable new orders will be compared to the Medication Administration Record (MAR) by the 11pm to 7am (24 hour chart check) nurse to assure order has been properly transcribed to the MAR. 2. Action taken/system put in place: a. 11pm to 7 am nurses will be in-serviced on completing chart checks each evening by 4/7/2017. b. All nurses will be in-serviced on the correct procedure in transcribing physician orders by 4/7/2017. c. MARs for the upcoming month will be double checked by administrative nurses against current monthly MARs. 3. How the corrective action(s) will be monitored to ensure the practice will not recur: a. Director of Nursing or designee will audit 10% of new orders to ensure accuracy of new order transcription. Audit weekly for four weeks, bi-weekly for one	

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F 281	Continued From page 53 glucose monitoring before meals with sliding scale coverage; and blood glucose monitoring at bedtime. An Interviewed was conducted on 3/2/16 at 9:55 am with the Director of Nursing (DON). The DON stated she expected all nurses to follow physician orders and to provide insulin or any other medication as ordered and to monitor the blood glucose. An interview was attempted via telephone with Nurse #4, but she was unavailable. 2. Resident #7 was admitted to the facility on 6/27/11 and most recently readmitted on 5/8/15 with multiple diagnoses that included anxiety and Alzheimer's. The plan of care for Resident #7 included the need/problem area of psychotropic medications. This need/problem area was initiated on Resident #7's care plan on 5/10/16. A physician's order dated 7/25/16 indicated Ativan (antianxiety medication) 0.25 milligrams (mg) once daily for Resident #7. The Minimum Data Set (MDS) assessment dated 1/25/17 indicated Resident #7 was rarely/never understood. She was assessed with short term and long term memory problems. Resident #7 had no noted behaviors or rejections of care. She was indicated to have received antianxiety medication on 7 of 7 days during the MDS review period. An MDS Care Area Assessment progress note for Resident #7's MDS dated 1/25/17 indicated she was combative and agitated at times.	F 281	month, and monthly for one month. b. At the beginning of each month 10% of MARs will be compared to last month MAR for accuracy. Audit weekly for four weeks, bi-weekly for one month, and monthly for one month. The QAPI Committee will review New Order audit for compliance monthly for three (3) months in the monthly QAPI meeting to assure compliance is sustained. Will re-evaluate for compliance for compliance and if compliance is not met will continue for another three (3) months.	

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A physician's order dated 2/14/17 indicated a discontinuation of the previous Ativan order (0.25mg once daily) and the initiation of Ativan 0.25mg twice daily for increased agitation for Resident #7.

A nursing progress note dated 2/14/17 indicated the physician was in the facility that morning (2/14/17) and had ordered an increase in the frequency of Ativan 0.25mg from once daily to twice daily for Resident #7.

Resident #7's plan of care related to psychotropic medications was updated on 2/14/17 with a new intervention, "[Resident #7] had an increase in agitation, change in medication [Ativan]".

A review of the February 2017 Medication Administration Record (MAR) for Resident #7 indicated she was administered Ativan 0.25mg once daily from 2/1/17 through 2/28/17. The physician ' s order dated 2/14/17 that indicated an increase in the frequency of Ativan 0.25mg from once daily to twice daily had not been transcribed onto Resident #7's February MAR. This resulted in 14 omitted doses of Ativan 0.25mg for Resident #7 from 2/15/17 through 2/28/17.

The March 2017 MAR for Resident #7 indicated the inclusion of the physician's order dated 2/14/17 for Ativan 0.25mg twice daily.

An interview was conducted with Director of Nursing (DON) on 3/2/17 at 11:20 AM. She reviewed the process for the transcription of new physician's order onto the MAR. She stated the nurse who obtained the order was responsible for transcribing the order onto the MAR. The physician's order dated 2/14/17 that indicated an

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increase in the frequency of Ativan 0.25mg once daily to twice daily for Resident #7 was reviewed with the DON. The February 2017 MAR for Resident #7 that revealed the 2/14/17 physician's order for an increase in the frequency of Ativan was not transcribed onto the MAR was reviewed with the DON. The DON stated Nurse #3 had obtained the 2/14/17 physician's order and she should have transcribed the order onto Resident #7's MAR. She indicated her expectation was for physician's orders to be followed.

An interview was conducted with Nurse #3 on 3/2/17 at 11:30 AM. She reviewed the process for the transcription of new physician's order onto the MAR. She stated the nurse who obtained the order was responsible for transcribing the order onto the MAR. The physician's order dated 2/14/17 that indicated an increase in the frequency of Ativan 0.25mg once daily to twice daily for Resident #7 was reviewed with Nurse #3. She stated she had had obtained that physician ' s order for Resident #7. The February 2017 MAR for Resident #7 that revealed the 2/14/17 physician's order for an increase in the frequency of Ativan was not transcribed onto the MAR was reviewed with Nurse #3. She indicated she was responsible for adding the 2/14/17 order onto Resident #7's February MAR. She stated she made a mistake by not transcribing the order.

A phone interview was conducted with Resident #7's physician on 3/2/17 at 12:35 PM. The physician's order dated 2/14/17 that indicated an increase in the frequency of Ativan 0.25mg once daily to twice daily for Resident #7 was reviewed with her physician. She indicated she recalled ordering the increase in frequency of Ativan due to staff ' s report of crying episodes and increased

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agitation for Resident #7. The February 2017 MAR for Resident #7 that revealed the 2/14/17 physician's order for an increase in the frequency of Ativan was not transcribed onto the MAR was reviewed the physician. She stated she had not been made aware the 2/14/17 order for Resident #7's Ativan had not been followed. She revealed it was a concern to her when her orders were not followed. The physician indicated it was her expectation for medications to be administered as ordered.

3. Resident #117 was admitted to the facility on 11/26/16 with multiple diagnoses that included cerebral infarction (stroke), hypertensive heart disease with heart failure, and type 2 Diabetes Mellitus.

The admission Minimum Data Set (MDS) assessment dated 12/2/16 indicated Resident #117 was cognitively intact.

A physician's order dated 12/21/16 indicated a dietary consultation for weight loss, Resource (nutritional supplement) 90 milliliters (ml) three times daily with medication pass, and Remeron (antidepressant and appetite stimulant) 7.5 milligrams (mg) once daily at bed time.

The December 2016 Medication Administration Record (MAR) for Resident #117 was reviewed. It indicated Resource 90 ml three times daily was added to the MAR on 12/21/16 and was administered to Resident #117 three times daily throughout the remainder of December. It also indicated Remeron 7.5mg once daily at bed time was added to the MAR on 12/22/16 and was administered to Resident #117 once daily at bed

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time the remainder of December.

The medical record indicated Resident #117 went on a leave of absence with family on 1/16/17. During the leave of absence she was admitted to the hospital on 1/19/17 and was discharged from the facility.

The January 2017 MAR from 1/1/17 through 1/16/17 for Resident #117 was reviewed. The MAR revealed no documentation of Resident #117 having been administered Remeron 7.5 mg once daily at bed time or Resource 90 ml three times daily.

An interview was conducted with the Director of Nursing (DON) on 2/28/17 at 12:18 PM. The January 2017 MAR for Resident #117 that indicated she had not been administered Resource 90 ml three times daily or Remeron 7.5mg once daily at bed time at any point from 1/1/17 through 1/16/17 was reviewed with the DON. She verified there was no evidence that Resident #117 received Resource or Remeron from 1/1/17 through 1/16/17.

A second interview was conducted with the DON on 2/28/17 at 2:20 PM. The DON provided a copy of a Medication Error Report form. She indicated the facility had identified multiple medication errors and had completed Medication Error Report forms on each error that had been identified. She revealed she had a "stack" of Medication Error Reports. She reported she had forgotten about this medication error for Resident #81 when she was interviewed earlier this day (2/28/17 at 12:18 PM). The form indicated a medication error was identified for Resident #117 on 1/17/17. Resident #117 was noted to have not

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F 281	Continued From page 58 received Remeron or Resource from 1/1/17 through 1/16/17 due to a transcription error on the MAR. The form revealed Resident #117 had a poor appetite and continued to lose weight. The DON indicated when the MARs for Resident #117 were transcribed from December 2016 to January 2017 the Remeron and Resource had been mistakenly omitted and the error was not identified until 1/17/17. She stated at the time of the error the MARs were transcribed by floor nurses and were not reviewed by Administrative Nurses. She indicated the Administrative Nurses had since been assisting with monthly MAR checks. A phone interview was conducted with the RD on 2/28/17 at 4:00 PM. She indicated she was familiar with Resident #117. The physician's order dated 12/21/16 for Remeron 7.5mg once daily at bed time and Resource 90 ml three times daily for Resident #117 were reviewed with the RD. The medication error report dated 1/17/17 that indicated Resident #117 had not received the ordered Remeron or Resource from 1/1/17 through 1/16/17 was reviewed with the RD. She indicated she had not been made aware of the error. She indicated she expected to be informed of those types of errors. A follow up interview was conducted with the DON on 3/2/17 at 10:40 AM. She indicated her expectation was for physician's orders to be followed.	F 281		
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,	F 282		4/14/17

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F 282	Continued From page 59 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 observation, staff interview, and record review, the facility failed to follow the care planned interventions for anticoagulant medication (Resident #81), dietary supplements (Resident #117), and restorative nursing services (Resident #42) for 3 of 17 resident's care plans reviewed. The findings included: 1. Resident #81 was initially admitted to the facility on 6/29/11 and most recently readmitted on 7/23/16 with diagnoses that included heart disease. The plan of care for Resident #81 included the need/problem area of anticoagulant drug use. This need/problem area was initiated on Resident #81's care plan on 9/20/16. The interventions included the administration of medications as ordered for Resident #81. A physician's order dated 11/25/16 indicated Coumadin (anticoagulant medication) 9.5 milligrams (mg) once daily at bed time for Resident #81. The annual Minimum Data Set (MDS) assessment dated 12/6/16. He was indicated to have received anticoagulant medication on 7 of 7 days during the MDS review period. A physician's order dated 12/7/16 indicated to	F 282	F282 Services by Qualified Persons Based on review, Resident # 81 is receiving Coumadin as ordered. The Director of Nursing (DON) and Nurse Consultant reviewed the Medication Administration Record (MAR) and current orders on 3/6/17. Resident #117's physician orders were reviewed by the DON on 3/6/17. Medication and supplements are being administered as ordered. Resident #42 is no longer in facility. All therapy screens for the last 60 days were reviewed on 4/6/17 by the Therapy Director to ensure that residents referred to Restorative program are receiving service. Review revealed all residents referred to the Restorative Program are being seen. All residents on Coumadin are monitored via the Coumadin Audit tracking toll that was initiated December 2016. All resident receiving Coumadin were reviewed for accuracy of their dosage ordered to the MAR by the DON on 3/6/17. The Coumadin Audit Tracking is maintained by the Director of Nurses (DON) and/or the Staff Development Coordinator. Facility Registered Dietician and Divisional	

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F 282	Continued From page 60 hold Resident #81's Coumadin (9.5mg) that evening (12/7/16) and then start Coumadin 9mg daily on 12/8/16. A physician's order dated 12/19/16 indicated "Draw PT/INR now" for Resident #81. A follow up physician's order was written on 12/19/16 that indicated a discontinuation of the previous Coumadin order and the start of Coumadin 9.5mg for Resident #81. A review of the December 2016 Medication Administration Record (MAR) for Resident #81 indicated he was administered 9.5mg of Coumadin once daily at bed time from 12/1/16 through 12/6/16 as ordered. On 12/7/16 the physician's order to hold Coumadin was followed for Resident #81. Further review of the MAR revealed on 12/8/16 through 12/18/16 Resident #81 was administered 9.5mg of Coumadin once daily at bed time instead of Coumadin 9mg once daily as ordered by the physician on 12/7/16. This resulted in 11 administrations of a higher dose of Coumadin than ordered for Resident #81. An interview was conducted with the Director of Nursing (DON) on 3/2/17 at 10:40 AM. She indicated her expectation was for care planned interventions to be followed and for medications to be administered as ordered by the physician. 2. Resident #117 was admitted to the facility on 11/26/16 with diagnoses that included cerebral infarction (stroke), hypertensive heart disease with heart failure, type 2 Diabetes Mellitus, and severe protein calorie malnutrition. The admission Minimum Data Set (MDS)	F 282	Registered Dietician completed a comparison of physician signed orders against Meal Tracker software to ensure 100% accuracy of diets and supplements on 3/23/17. All residents were reviewed to ensure dietary supplements were being given as ordered by the Facility Registered Dietician and the Divisional Registered Dietician. New referrals from therapy will be given to the Director of Nurses (DON). DON will bring referral to Morning Clinical Meeting, referral will be given to MDS Coordinator to be care planned and verified with Restorative that resident is on current restorative case load. Audit for tracking therapy to restorative referrals will be audited in the Morning Clinical Meeting by the Restorative Nurse. Restorative referrals audit will be done weekly for one month; then twice a /month for one month, then monthly for one month by the Restorative Nurse. Restorative Nurse will also visually validate the Restorative Certified Nursing Assistances are working with the resident being audited. The QAPI Committee will review audit results for compliance monthly for three (3) months in the monthly QAPI meeting to assure compliance is sustained. Will re-evaluate for compliance for and if compliance is not met will continue for another three (3) months. The DON will be responsible for brining the Coumadin Audit log summary to the QAPI Committee. Facility Dietician or the Food	

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F 282	Continued From page 61 assessment dated 12/2/16 indicated Resident #117 was cognitively intact. She required supervision from staff with set up assistance only for eating. Resident #117 was assessed with no swallowing issues and she was indicated to be edentulous (no natural teeth). On 1/13/17 the plan of care for Resident #117 was updated to include the need/problem area of weight loss. The interventions included the provision of a dietary supplement as ordered. The January 2017 MAR from 1/13/17 through 1/16/17 for Resident #117 was reviewed. The MAR revealed no documentation of Resident #117 having been administered or Resource 90 milliliters (ml) three times daily. An interview was conducted with the DON on 2/28/17 at 12:18 PM. The January 2017 MAR for Resident #117 that indicated she had not been administered Resource 90ml three times daily at any point from 1/13/17 through 1/16/17 was reviewed with the DON. She verified there was no evidence that Resident #117 received Resource 1/13/17 through 1/16/17. A follow up interview was conducted with the DON on 3/2/17 at 10:40 AM. She indicated her expectation was for the care planned interventions to be followed and for dietary supplements to be provided as ordered. 3. Resident #42 was admitted 8/22/16 with cumulative diagnoses of epilepsy, diabetes and anemia. Resident #42 ' s quarterly Minimum Data Set	F 282	Service Director (CDM) will bring audits of dietary supplements being given as ordered to the QAPI meeting. The Restorative Nurse will bring the results to the QAPI meeting for regarding referrals to Restorative being treated.	

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(MDS) dated 11/22/16 indicated moderate cognitive impairment with no behaviors. He was coded as independent with transfers, bed mobility and ambulating in his room. Resident #42 was coded for supervision with ambulating in the halls, toileting, hygiene and bathing. He was not coded for any falls.

Resident #42 was care planned on 9/14/16 for a moderate risk for falls. This care plan was last reviewed on 11/29/16. Resident #42 ' s care plan was updated on 1/25/17 to include actual falls with interventions to include frequent rounds, non-skid socks, re-education to call for assistance and a therapy referral.

Resident #42 sustained falls on 1/23/17, 1/25/17, and 2/6/17 and again on 2/22/17.

A therapy screen was completed 1/25/17. The screen indicated restorative nursing was ordered for a maintenance program to include active range of motion (AROM) to his bilateral lower extremities for 15 minutes 6 days a week and ambulation using a rolling walker 100 feet with two person assistance 6 days a week. The actual Therapy Communication Form completed by the physical therapist was dated 2/3/17 and was signed off by the staff development coordinator (SDC) acknowledging education of the prescribed restorative program.

Resident #42 ' s care plan was updated by the SDC on 2/4/17 for include AROM to both lower extremities and ambulation 100 feet with 2 person assistance.

A review of the Restorative Care Flow Record for

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February 2017 in the paper medical record listed ambulation and active range of motion 6 days a week starting on 2/6/17 and indicated Resident #42 was discharged from restorative on 2/15/17. There were no minutes listed and no restorative aide (RA) initials indicating Resident #42 received services.

In an interview on 2/27/7 at 9:27 AM, Resident #42 stated he had not received any restorative services that he could recall.

In an interview on 2/28/17 at 12:00 PM, the Rehabilitation Director stated the physical therapist completed the restorative referral on 2/3/17 and the referrals were usually given to the SDC or the MDS nurse at the time the Therapy Communication Form was completed.

In an interview on 2/28/17 at 12:15 PM, the SDC stated he completed the restorative care plan dated 2/4/17 for AROM and ambulation but he was uncertain why the services were not started. He stated it was his understanding the MDS nurse was over restorative nursing up until this week when she went out on medical leave. He stated he was unable to provide any restorative documentation from 2/3/16 to 2/15/17.

In an interview on 3/1/17 at 10:10 AM, RA #1 and RA #2 stated they did not recall doing restorative nursing with Resident #42. RA #1 stated if he was on their caseload, they would have documented their minutes on the Restorative Care Flow Record. RA #1 and RA #2 stated they normally got their assignments from either the MDS nurse or the SDC.

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F 282	Continued From page 64 In an interview on 3/2/17 at 9:30 AM, the DON stated it was her expectation that Resident #42 would have received the restorative services as care planned.	F 282		
F 285 SS=D	483.20(e)(k)(1)-(4) PASRR REQUIREMENTS FOR MI & MR (e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: (1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. (2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. (k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. (1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation	F 285		4/14/17

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performed by a person or entity other than the State mental health authority, prior to admission,

(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and

(B) If the individual requires such level of services, whether the individual requires specialized services; or

(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-

(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and

(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

(2) Exceptions. For purposes of this section-

(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.

(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission

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F 285	Continued From page 66 to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. (3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. (k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to incorporate a Preadmission Screen and Resident Review (PASRR) level II determination related to Serious Mental Illness	F 285	F285 PASRR Requirements Resident #81,s level 2 PASRR for SMI was incorporated into his care plan on 3/3/2017 by the MDS Coordinator. Care	

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F 285	Continued From page 67 (SMI) into the plan of care for 1 of 1 residents (Resident #81) reviewed for PASRR level II. The findings included: Resident #81 was initially admitted to the facility on 6/29/11 and most recently readmitted on 7/23/16 with diagnoses that included psychosis, depression, delirium due to known physiological factors, and other problems related to psychosocial circumstances. A review of the medical record indicated Resident #82 had a PASRR level II related to SMI. The annual Minimum Data Set (MDS) assessment dated 12/6/16 indicated Resident #81 had moderate cognitive impairment. He was assessed as a PASRR level II for SMI. Resident #81 indicated he had little interest or pleasure in doing things on 7-11 days during the 14 day review period. He was assessed with no behaviors and no rejection of care. An MDS Care Area Note (CAA) for the 12/6/16 MDS indicated Resident #81 had paranoid schizophrenia and oppositional defiant disorder. The CAA for Cognitive Loss and Dementia were indicated not to be care planned at that time for Resident #81 as it was presently not a problem. The CAA for Psychosocial Well Being was indicated to be triggered by the MDS assessment, but was not to be care planned at that time for Resident #81 as there were not currently any issues. A social service note date 12/7/16 indicated Resident #81 was a PASRR level II. A review of Resident #81's comprehensive plan	F 285	plan for PASRR level 2 indicating the diagnosis and potential for complications related to diagnosis were added. On 3/3/2017, the Clinical Nurse Consultant in-serviced the MDS Coordinator on incorporating PASRR level 2 information into care plans. The Admission Coordinator conducted an audit on each resident's PASRR level on 3/27/2017. Any residents identified during audit with a PASRR level 2 will have a PASRR level 2 incorporated into the plan of care. There were found to be 15 residents with a PASRR level 2. All of these have been care planned to reviewed and updated to reflect PASRR level 2 presence. The Admission Coordinator will verify new admissions' PASRR screening. When completed ,the Admission Coordinator will notify the MDS Coordinator if resident has a PASRR level 2. The Administrator and/or Social Service Director will audit all new residents and 10% of current residents for accuracy of PASRR level 2 and corresponding care plan monthly for 3 months. The QAPI Committee will review audit results for compliance monthly for three (3) months in the monthly QAPI meeting to assure compliance is sustained. Will re-evaluate for compliance for compliance and if compliance is not met will continue for another three (3) months. Social Service Director will bring audit results to the QAPI Committee Meeting.	

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F 285	Continued From page 68 of care, most recently revised on 2/27/17, revealed no identification or incorporation of his PASRR level II determination for SMI. An interview was conducted with the Director of Nursing (DON) on 3/2/17 at 10:40 AM. She indicated it was her expectation that plans of care be comprehensive, accurate, and followed. She stated she was unsure how the PASRR level II determinations were incorporated in the care planning process. The DON indicated that was a question for the MDS Coordinator. An interview was conducted with the MDS Coordinator on 3/2/17 at 12:18 PM. She stated she began working at the facility on 2/20/17. She indicated the previous MDS Coordinator no longer worked at the facility. She stated that creating and revising plans of care was her responsibility. The plan of care for Resident #81 was reviewed. She stated she had not completed the plan of care for Resident #81, but revealed it was her expectation that his level 2 PASRR determination for SMI was incorporated into his plan of care.	F 285		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES 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.	F 309		4/14/17

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F 309	Continued From page 69 483.25 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 reviews, physician interview, and staff interviews, the facility failed to administer a Fentanyl patch (pain medication) for a resident which resulted in increased pain and increased need and request for as needed Percocet (pain medication) for 1 out of 2 sampled residents (Resident #40) reviewed for pain. Findings include: Resident #40 had diagnoses of osteoarthritis, cervical laminectomy, and chronic pain syndrome. According to the quarterly minimum data set dated 11/23/16, the resident required assistance with activities of daily living by one	F 309	F309 Care and Services Resident #40 is receiving fentanyl patch and prn Percocet. Pain assessment was completed for resident #40 on 3/23/2017 by her staff nurse. Plan of care was updated on 3/23/2017 by the MDS LPN Coordinator to reflect pain management program, which includes non- pharmacological interventions. Interview with resident #40 has been completed to ensure pain is managed to her satisfaction. Interview was conducted	

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F 309	Continued From page 70 staff member and was moderately cognitively impaired. Resident #40's care plan addressed administration of pain medication and use of other modalities. The care plan intervention was to administer pain medication as ordered and to evaluate for effect. The care plan was reviewed quarterly, and the last review was on 1/12/17. Record review revealed a physician's order dated 1/1/17 for a Fentanyl Transdermal Patch 50 micrograms (mcg) per hour, topically every 72 hours. [The Fentanyl Patch is indicated for management of persistent, moderate to severe chronic pain.] The resident also had an order dated 1/1/17 for Percocet 10-325 milligrams every six hours as needed for pain. Resident #40's January 2017 Medication Administration Record (MAR) was reviewed. The MAR indicated the Fentanyl Patch was to be applied on 1/20/17. The date was circled, which indicated the medication had not been given. Further review of the MAR revealed that prior to 1/20/17, Resident #40 was asking for Percocet once a day, when the new patch was not applied on 1/20/17, the resident asked for the Percocet more often. Percocet was administered twice on 1/20/17, twice on 1/21/17, three times on 1/22/17, and three times on 1/23/17. A review of the medication error report dated 1/23/17 was reviewed and included, Description of error: "(Resident #40's) Fentanyl patch 50 mcg/hour apply one patch topically every 72 hours was scheduled to be applied on 1/20/17 and it was not. The Fentanyl patch was missed. The Fentanyl patch was applied 1/23/17 and the medication error was identified." Type of error: "medication was not given." The reason for error: "the medication was overlooked." Measures taken to prevent the recurrence of similar error(s):	F 309	by DON. Resident states she is satisfied with the management of her pain. Education for all nurses on importance of administrating medication as ordered will be completed by Omnicare Pharmacy or Director of Nursing by 4/14/2017. All Nurses will be in-serviced on pain management to include non-pharmacological interventions by Director of Nursing or Staff Development Coordinator by 4/14/ 2017. Pain will be assessed at least each shift and documented on Medication Administration Record (MAR) for all residents by the floor nurse. Identified pain will be addressed appropriately. All residents will have comprehensive pain assessment completed on admission, re-admission, quarterly, and with any significant change as assigned to the floor nurse providing care. All resident who have pain medication scheduled will have a pain management care plan reviewed, updated or initiated by the MDS LPN Coordinator by 4/13/17. An audit of all residents receiving scheduled fentanyl pain patches will be completed by the Medical Records clerk by 4/13/17 to determine if any other omissions occurred. She will review March 2017 MAR's and April MAR's to date. The Treatment Nurse will conduct an audit monthly for three (3) months, on 25% of the MAR's for residents with scheduled fentanyl patches to determine if omissions have occurred. The QAPI Committee will review monitor	

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F 309	Continued From page 71 "Nurse education and medication pass audit." According to the medication error report, the Director of Nursing (DON) was notified on 1/23/17 at 11:05 am and Physician #1 was notified on 1/23/17 at 11:10 am. An interview was conducted on 2/28/17 at 4:50 pm with Resident #40. The resident stated she remembered that her Fentanyl patch was missed one time last month. The miss was discovered when the next Fentanyl patch was due. During the missed period, the resident stated she had pain level 10 on a scale of 1-10 (with 10 being the worst pain) and had asked for as needed Percocet more often to relieve the pain. The resident stated she noticed the pain was not relieved as usual. An interview was conducted on 3/1/17 at 12:30 pm with Physician #1 regarding Resident #40's missed Fentanyl patch on 1/20/17. Physician #1 stated care does not meet expectation if the resident had pain even with the as needed Percocet. Physician #1 stated he expected the Fentanyl order to be followed. An interview was attempted with Nurse #6 on 3/2/17 and 3/3/17, but Nurse #6 was not available. An interview was conducted with the Director of Nursing (DON) 3/2/17 at 10:40 am regarding the staff's responsibility to follow physician's orders. The DON stated that she expected staff to follow physician's orders.	F 309	for compliance monthly for three (3) months in the monthly QAPI meeting to assure compliance is sustained. Will re-evaluate for compliance for compliance and if compliance is not met will continue for another three (3) months. Treatment nurse will bring the results of the random audit to the QAPI Committee meeting.	
F 315 SS=G	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	F 315		4/14/17

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F 315	Continued From page 72 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 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 record review, observation and staff interview, the facility failed to provide catheter care and failed to secure the catheter tubing for 1 (Resident #4) of 1 sampled resident with an indwelling urinary catheter. Resident #4 had three hospitalizations with diagnoses of Urinary	F 315	F315 No Catheter/Prevent UTI Resident #4's urinary catheter was discontinued on 3/15/2017 per physician order. All residents identified with a urinary catheter have a plan of care in place as	

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F 315	Continued From page 73 Tract Infection (UTI). Findings included: Resident #4 was originally admitted to the facility on 12/1/16 with multiple diagnoses including renal insufficiency. The admission Minimum Data Set (MDS) assessment dated 12/7/16 indicated that Resident #4 had severe cognitive impairment and she was frequently incontinent of bladder. Resident #4 had a doctor's order dated 12/7/16 to insert an indwelling urinary catheter due to unstageable pressure ulcer on the left buttock. Resident #4's physician's orders for December 2016, January and February 2017 were reviewed. Resident #4 did not have an order for catheter care or for securing the urinary catheter. Resident #4's care plan dated 12/8/16 was reviewed. One of the care plan problems was resident had an indwelling urinary catheter and she was at risk for increased UTI. The goal was the catheter would remain patent and the resident would not develop increased incidence of UTI over the next 90 days. The approaches included to change catheter tubing and bag per doctor's order, monitor urine for odor, sediments and amount of urine and report abnormal to the doctor, encourage fluid intake within dietary limits, keep tubing and bag below the bladder, do not kink tubing and catheter care per doctor's order. The care plan also indicated that Resident #4 had pulled out her urinary catheter on 12/22/16 and 2/27/17. The medical records of Resident #4 revealed that she was discharged to the hospital on 12/15/16, 1/12/17 and 2/10/17.	F 315	verified by MDS LPN Coordinator on 3/27/2017. All residents with urinary catheters were observed on 4/5/17, by the treatment nurse to ensure that catheters were in place and secured. The treatment nurse reports that all residents with urinary catheters were in place and secure. One resident refuses drainage bag cover and will move his drainage up above waist while he is up in wheel chair. He refuses to have it placed lower while he is in wheel chair. All nursing staff will be in-serviced on catheter care, per facility policy, by the Nurse Consultant by 4/14/2017 a. Facility Policy: i. Gather supplies and set up ii. Explain procedure prior to beginning iii. Position resident on back, place protective covering on linens iv. Wash hand and put on gloves v. Wash area front to back, side then other side, then center always turning cloth to clean area before moving to next area. Clean stool prior to starting peri/catheter care. vi. Hold catheter gently but firmly near insertion site. Clean at insertion site then down the catheter with a twisting motion away from the body. vii. Rinse and dry viii. Attach tubing to inner thigh using a fastening devise ix. Place drainage bag in a cover and secure below resident waist. x. Clean area xi. Position resident for comfort xii. Report anything abnormal to nurse for	

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F 315	Continued From page 74 The hospital records of Resident #4 were reviewed. The hospital discharge summary with admission date of 12/15 through 12/20/16 revealed a diagnosis of "poly microbial UTI secondary to E coli and enterococcus." The hospital discharge summary with admission date of 1/12/ through 1/16/17 revealed a diagnosis of "toxic metabolic encephalopathy secondary to UTI and E coli UTI." The hospital discharge summary with admission date of 2/10 through 2/17/17 revealed a diagnosis of "UTI with sepsis-catheter associated UTI." On 2/28/17 at 4:10 PM, Resident #4 was observed in bed with an indwelling urinary catheter in place. The urinary catheter tubing was not secured during the observation. On 3/1/17 at 9:05 AM, Resident #4 was observed in bed with an indwelling urinary catheter in place. The urinary catheter tubing was not secured during the observation. On 3/1/17 at 9:06 AM, Nurse #3 was interviewed. Nurse #3 stated that she was the nurse assigned to Resident #4. She stated that the Treatment Nurse was responsible for providing catheter care and for ensuring the catheter tubing was secured. She also indicated that Resident #4 had history of pulling her catheter out and the last time she pulled it out was on 2/27/17. On 3/1/17 at 9:08 AM, NA #6 was interviewed. NA #6 stated that the nurses were responsible for catheter care but she had cleaned the urinary catheter during incontinent care when the resident had a bowel movement.	F 315	follow up. The Treatment Nurse, on 3/27/17, added Catheter care to the Certified Nursing Assistants documentation on the Activity of Daily Living tracking form for all residents with a urinary catheter. Catheter care was observed by Nurse Consultants from 3/28/17-3/30/17. Floor nurses will be responsible each shift for checking that urinary catheters are in place and secured. They will document this on the MAR through the month of April Audits will be done by the 11pm-7am Charge Nurse of all residents with a urinary catheter to ensure documentation of catheter care will be done weekly for one month; then random audits will be done monthly for three (3) months to ensure compliance. 11pm-7am Charge Nurse will compile results and provide to Staff Development Coordinator to turn into Staff Development Coordinator weekly. Unit Manager and/or staff nurse will observe Certified Nurse Aides providing urinary catheter care each shift weekly for two weeks then twice a month for one month, then monthly for one month for all residents with indwelling urinary catheters. Observations will be documented and turned in to the Staff Development Coordinator. The QAPI Committee will review audit results for compliance monthly for three (3) months in the monthly QAPI meeting to assure compliance is sustained. Will re-evaluate for compliance for compliance and if compliance is not met will continue for another three (3) months. Staff	

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F 315	Continued From page 75 On 3/1/17 at 9:12 AM, the Treatment Nurse was interviewed. She stated that the nurses working on the floor were responsible for providing catheter care and for securing the urinary catheter tubing. The Treatment Nurse indicated that she was only responsible for providing care to suprapubic catheter and not indwelling urinary catheter. At 10:40 AM, the Treatment Nurse indicated that Resident #4 had pulled out her catheter on 2/27/17 and the nurse, who reinserted the urinary catheter, forgot to secure the catheter tubing. On 3/2/17 at 10:45 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the catheter tubing to be secured at all times and catheter care to be provided to residents with a urinary catheter. She also indicated that the nursing aides were responsible for providing catheter care every shift but she could not find documentation that catheter care was provided to Resident #4.	F 315	Development Coordinator will bring results to the QAPI meeting.	
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility	F 323		4/14/17

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F 323	Continued From page 76 must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews and record review, the facility failed to investigate the root cause of 2 falls and failed to monitor for delayed complications related to a fall for 1 of 2 sampled residents reviewed for accidents. Findings included: Resident #42 was admitted 8/22/16 with cumulative diagnoses of epilepsy, diabetes and anemia. Resident #42's quarterly Minimum Data Set (MDS) dated 11/22/16 indicated moderate cognitive impairment with no behaviors. He was coded as independent with transfers, bed mobility and ambulating in his room. Resident #42 was coded for supervision with ambulating in the halls, toileting, hygiene and bathing. He was coded as continent of bladder and bowel and not coded for any falls. Resident #42's Fall Risk Assessment was last	F 323	F323 Accidents and Hazards Resident #42 is no longer at the facility. Nurses and Certified Nursing Aides were in-serviced by the Director of Nursing (DON), Staff Development Coordinator, and the Nurse Consultant on Prevention and Reporting of Accidents / Incidents on March 2, 2017. Department heads were educated on 3/22/2017 concerning Root Cause Analysis by the Risk Control Specialist from TIS Health Care Service Division. All Department heads were educated concerning Accident/Incidents on 3/23/2017 by Risk Control Specialist from TIS Health Care Service Division. All nursing staff will be re-educated on Accident/Incident investigations by 4/14/2017 by DON or Staff Development Coordinator. Policy and Procedures related to falls were in-serviced with all staff on 3/14/2017 i. All Accidents/incidents will have an	

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F 323	Continued From page 77 updated 11/22/16 and it indicated moderate risk for falls. Resident #42 was care planned on 9/14/16 for a moderate risk for falls. This care plan was last reviewed on 11/29/16. Resident #42's care plan was updated on 1/25/17 to include actual falls with interventions to include frequent rounds, non-skid socks, re-education to call for assistance and a therapy referral. The most recent care plan revision dated 2/10/17 indicated Resident #42 was receiving physical therapy for muscle weakness and unsteady gait. A review of the facility policy titled "Assessing Falls and Their Causes" last revised October 2010 read nursing staff were to observe a resident after a fall for a delayed complication for approximately 48 hours after an observed or suspected fall. The policy also read that nursing staff were to identify the possible cause of the fall. A review of the incidents logs revealed Resident #42 sustained falls on 1/23/17, 1/25/17, and 2/6/17 and again on 2/22/17. The incident reports indicated the following: -1/23/17 at 5:10 PM, Resident #42 was found on the floor in front of his recliner. He stated he was getting up from the recliner to get into his wheelchair when he slipped onto the floor. There were no injuries. The root cause was indicated as poor safety awareness and unassisted transfer. It noted increased swelling to bilateral feet. Interventions included a therapy consult, neurological checks and he was encouraged to call for assistance with transfers.	F 323	Accident/Incident form completed on the shift it occurred or was noted. ii. Witness statements will be obtained from all involved. iii. Staff is to maintain the safety of the resident. iv. Appropriate preventive interventions will be initiated on recognition of fall risk and after each fall will be updated. v. DON or Staff Development Coordinator will investigate all falls for root cause. Initiation of appropriate intervention will be put in place based on root cause analysis. New referrals from Therapy for Restorative Nursing will be given to the DON. DON will bring referral to the Morning Clinical Meeting, referrals will be given to MDS Coordinator to be cared planned and verified with Restorative Nursing that resident is on current case load. The Master Incident Log was revised to include environmental assessment on falls. Falls identified as having a possible environmental factor will be evaluated by Maintenance Director or facility Administrator. All residents will have a fall risk assessment completed by the Treatment Nurse. Residents identified as a fall risk will have a fall care plan and measures to prevent falls updated or initiated. This will be completed by 4/13/2017. All falls through March 31, 2017 were reviewed. There were 25 falls in February and 10 falls in March. 6 falls were related to unsteady gait, 15 were related to	

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F 323	Continued From page 78 A review of the paper medical record revealed the nursing staff obtained neurological checks and monitored Resident #42 as ordered for the fall that occurred on 1/23/17 from his personal recliner. There was no mention of an assessment of how he transfers from his personal recliner as a potential fall hazard. -1/25/17 at 7:45 AM. Resident #42 was observed sitting on the floor in front of the toilet. He stated the wheelchair folded up behind him with the wheelchair brakes on. There were no injuries. He was barefooted. The root cause was listed as improper footwear and poor safety awareness. Interventions included a therapy consult, neurological check and non-skid socks. Resident #42 was also re-educated to call for assistance. A review of the paper medical record revealed the nursing staff failed to obtain neurological checks or document any monitoring after the fall that occurred on 1/25/17 while toileting. A therapy screen was completed and he was referred to restorative nursing for ambulation on 2/3/17. A review of the Restorative Care Flow Record for February 2017 in the paper medical record listed ambulation and active range of motion 6 days a week starting on 2/6/17 and indicated Resident #42 was discharged from restorative on 2/15/17. There were no minutes listed and no restorative aide (RA) initials indicating Resident #42 received services.	F 323	confusion, 1 equipment issue, 3 behavior related, 1 related to positioning, 8 were related to resident who over estimated their ability to perform a task and 1 related to another resident in a wheelchair. Master Incident Log will be updated in Morning Clinical Meeting Monday through Friday. Weekend incidents will be added to the Master Incident Log on following Monday. Master Incident Log will be completed by Administrator or DON. New referrals from therapy to Restorative Nursing will be given to the DON/ designee. DON will bring referrals to Morning Clinical meeting; referral will be given to the MDS Coordinator to be cared planned and verified with Restorative Nursing to ensure resident is on their case load. Restorative referrals audit will be done weekly for one month, twice a month for one month, then monthly for one month by the Restorative Nurse. Restorative Nurse will also visually validate the Restorative Certified Nursing Assistants are working with the residents being audited. The QAPI Committee will review audit results from Master Log Form and Restorative Referrals for compliance monthly for three (3) months in the monthly QAPI meeting to assure compliance is sustained. Will re-evaluate for compliance. If compliance is not met review will continue for another three (3) months. The Director of Nursing will be responsible for bringing the Coumadin Audit log summary to the monthly QAPI Meetings. The Food Service Director will	

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F 323	Continued From page 79 -2/6/17 at 4:30 PM Resident #42 was observed sitting on the floor with his back against the wall next to the bathroom. He stated he was getting something in the closet and his legs became weak. He stated he leaned against the closet door and slid to the floor. There were no injuries. The root cause was identified as unsteady gait and lower extremity weakness. Resident #42 was encouraged to call for assistance with getting his clothes out of the closet, a therapy consult and neurological checks. A review of the paper medical record revealed the nursing staff obtained neurological checks and monitored Resident #42 as ordered for the fall that occurred on 2/6/17 while trying to retrieve clothes from his closet. -2/21/17 at 10:05 PM, Resident #42 was observed sitting upright in front of his recliner. He stated he was transferring from the recliner to the wheelchair to go to bed. The root cause was unsteady gait, unassisted transfers and poor safety awareness. Interventions included therapy consult, neurological check and re-education to call for assistance. The form indicated Resident #42 was already receiving physical therapy. A review of the paper medical record revealed the nursing staff obtained neurological checks and monitored Resident #42 as ordered for the fall that occurred on 2/21/17 from his personal recliner. There was no mention of an assessment of how he transfers from his personal recliner as a potential fall hazard.	F 323	bring audits of dietary supplements to the monthly QAPI meetings. The Restorative Nurse will bring the results of the restorative audits to the monthly QAPI Meetings. Date of Compliance 4/14/17	

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F 323	Continued From page 80	F 323		

A review of the physical therapy discharge summary indicated Resident #42 was on caseload from 2/10/17 until 2/24/17 when he reached his maximum potential. A restorative referral was completed on 2/24/17.

In an interview on 2/27/17 at 9:17 AM, Resident #42 cautioned the surveyor against sitting in his personal recliner because it would tip forward and it was easy to slide out onto the floor. He stated he had fallen twice trying to get up from the recliner.

In an interview on 3/1/17 at 10:10 AM, RA #1 and RA #2 stated they did not recall doing restorative with Resident #42. RA #1 stated if he was on their caseload, they would have documented their minutes on the Restorative Care Flow Record. RA #1 and RA #2 stated they normally got their assignments from either the MDS nurse or the Staff Development Coordinator (SDC).

In an interview on 3/1/17 at 3:00 PM, the rehabilitation director stated the facility met and reviewed falls weekly to find the root cause. She stated she did not realize until 3/1/17 that two of Resident #42 ' s occurred from his personal recliner. The rehabilitation director stated Resident #42 ' s family brought the recliner from home but it should have been assessed for safety and it should have been evaluated after he fell from it on 1/23/17.

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F 323	Continued From page 81 In an interview on 3/1/17 at 3:40 PM, the SDC stated he did not realize the fall on 1/23/17 and 2/21/17 were from Resident #42 ' s personal recliner. He stated the recliner should have been assessed for safety and if it needed some non-skid material in the seat or maybe needed to be removed, it should have been addressed before 3/1/17. The SDC stated it was the facility practice to do neurological checks and monitor residents who fall for 48 hours after the fall but was unable to explain why no follow up monitoring or assessment was done after the fall on 1/25/17. In an interview on 3/2/17 at 9:30 AM, the Director of Nursing stated it was her expectation that Resident #42's personal recliner would have been assessed for a possible fall hazard. She further stated it was her expectation that Resident #42 would have been monitored for 48 hours after his fall on 1/25/17.	F 323		
F 325 SS=D	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE (g) Assisted nutrition and hydration. (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	F 325		4/14/17

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F 325	Continued From page 82 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 observation, staff interview, and record review, the facility failed to follow the physician's orders for Remeron (appetite stimulant/antidepressant) and Resource (nutritional supplement) for a resident with significant weight loss (Resident #117) and failed to address weight loss (Resident #87) for 2 of sampled 3 residents reviewed for Nutrition. The findings included: 1. Resident #117 was admitted to the facility on 11/26/16 with diagnoses that included cerebral infarction (stroke), hypertensive heart disease with heart failure, and type 2 Diabetes Mellitus. A Nutrition/Dietary note from the Dietary Manager (DM) dated 12/1/16 indicated Resident #117 was admitted on a No Added Salt (NAS) diet. Resident #117's weight was 109 pounds (lbs). The plan of care for Resident #117, initiated on 12/1/16, included the need/problem area of a therapeutic NAS diet. The goal for Resident #117 included no significant weight loss during the 90 day review period. The admission Minimum Data Set (MDS) assessment dated 12/2/16 indicated Resident #117 was cognitively intact. She required supervision from staff with set up assistance for eating. Resident #117 was assessed with no swallowing issues and she was indicated to be	F 325	F325 Nutrition Status Resident #117: On 3/22/17, the Regional Registered Dietician reviewed resident's status. She recommended diet liberalization to regular/mechanical soft with thin liquids to maximize intake, magic cup every day at lunch for nutritional support and to increase protein, house supplement 120ml three times a day and discontinue ensure. Change supplement to provide increased calories and protein for low protein level and aide wound healing, and add vitamin C and zinc for 14 days to promote wound healing. The physician approved the recommendations. Resident #87: The Regional Registered Dietician reviewed resident's status on 3/23/17. She Recommended discontinuation of protein powder orders secondary to increased protein provide by recommended supplements of house supplement and magic cups. Physician approved recommendations. Weight management plans of care for both Residents #87 and #117 have been reviewed and updated by the MDS LPN Coordinator. Residents will be weighed weekly and discussed in Standard Of Care (SOC) meeting weekly to ensure residents' nutritional needs are being met. Consultant Pharmacist reviewed	

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F 325	Continued From page 83 edentulous (no natural teeth). Her documented weight was 109 lbs. A DM note dated 12/8/16 indicated Resident #117's weight was 104 lbs. Resident #117 reportedly consumed 45-50% of meals. No changes were indicated for Resident #117 ' s diet. A physician's order dated 12/21/16 indicated a dietary consultation for weight loss, Resource (nutritional supplement) 90 milliliters (ml) three times daily with medication pass, and Remeron (antidepressant and appetite stimulant) 7.5 milligrams (mg) once daily at bed time. A DM note dated 12/22/16 indicated Resident #117's weight was 103 lbs. Her weight was down 6 lbs since 12/1/16 (109 lbs). A Registered Dietician (RD) note dated 12/22/16 indicated Resident #117's weights included 12/13/16: 103 lbs and 12/1/16: 109 lbs. She was recently ordered a nutritional supplement and Remeron. Laboratory results dated 12/7/16 indicated Resident #117 had low Albumin (measurement of protein) results of 3.4 (normal range was 3.5-5.0). The RD had no additional recommendations for Resident #117 at that time. Laboratory results dated 12/30/16 indicated Resident #117 had low Albumin results of 2.8. The December 2016 Medication Administration Record (MAR) for Resident #117 was reviewed. It indicated Resource 90 ml three times daily was added to the MAR on 12/21/16 and was administered to Resident #117 three times daily throughout the remainder of December. It also indicated Remeron 7.5mg once daily at bed time	F 325	medications for Resident #117 on 3/28/17 and recommended a Hemoglobin A1C be ordered. The Consultant Pharmacist reviewed medications for resident # 87 on 3/28/17 and recommended reducing dosage of Lexapro. Physician accepted recommendation and order was carried out. Resident #87 and #117, all physician orders were reviewed by the Director of Nursing (DON) on 3/6/17. Medications are being administered as ordered. Facility Registered Dietician and Divisional Registered Dietician will complete a comparison of physician signed orders against Meal Tracker software to ensure 100% accuracy of diets and supplements by 4/14/17. Residents with significant weight loss noted will be weighed weekly until weight is stable. Residents with significant weight loss will be discussed in SOC meeting weekly until weight is stable or it determined resident is “Unavoidable Weight Loss”. Food Service Director (CDM) will generate the list of those residents with significant weight loss to be weighed weekly. Staff Nurses may contact the Food Service Director (CDM) to add to this list resident’s they suspect have a weight loss. All new admissions and newly identified residents with weight loss will be communicated with facility Registered Dietician by the Food Service Director (CDM). These residents will also be added to the weekly weight list maintained by the Food Service Director. Restorative Certified Nursing Assistants	

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F 325	Continued From page 84 was added to the MAR on 12/22/16 and was administered to Resident #117 once daily at bed time the remainder of December. Resident #117's weight record indicated a weight of 94 lbs on 1/4/17. This was a 14% weight loss since 12/1/16 (109 lbs) for Resident #117. On 1/13/17 the plan of care for Resident #117 was updated to include the need/problem area of weight loss. The interventions included the provision of a dietary supplement as ordered. The medical record indicated Resident #117 went on a leave of absence with family on 1/16/17. During the leave of absence she was admitted to the hospital on 1/19/17 and was discharged from the facility. The January 2017 MAR from 1/1/17 through 1/16/17 for Resident #117 was reviewed. The MAR revealed no documentation of Resident #117 having been administered Remeron 7.5 mg once daily at bed time or Resource 90 ml three times daily. An interview was conducted with the Director of Nursing (DON) on 2/28/17 at 12:18 PM. The January 2017 MAR for Resident #117 that indicated she had not been administered Resource 90 ml three times daily or Remeron 7.5mg once daily at bed time at any point from 1/1/17 through 1/16/17 was reviewed with the DON. She verified there was no evidence that Resident #117 received Resource or Remeron from 1/1/17 through 1/16/17. A second interview was conducted with the DON on 2/28/17 at 2:20 PM. The DON provided a	F 325	(RCNA) weigh all residents. They will follow facility policy to weigh all new admissions weekly x4, then monthly unless otherwise indicated by the Restorative Nurse upon review of weights. All residents are weighed monthly. Residents with significant weight changes will be weighed weekly at direction of Restorative Nurse or by agreement of the SOC Committee (members include: DON, Staff Development/Restorative Nurse, MDS LPN Coordinator, Treatment Nurse, Food Service Director, Social Service Director and therapy representative.) All resident's weights were reviewed for significant changes in weight by the Divisional and Facility Registered Dieticians on 3/23/2017 and 4/7/17. Another audit checking for weight loss will be done on 4/11/17. Care plans were updated by the Divisional and Facility Registered Dieticians and by the Food Service Directors. Facility Registered Dietician will communicate his/her findings to the Administrator and Director of Nursing. Weights are monitored weekly by the CDM. Residents with significant weight loss will be reviewed in Standards Of Care (SOC) meeting weekly until weight is stable. Food Service Director will bring printed copies of weights to SOC meeting for all members to review. This is an ongoing process to manage significant weight changes in the facility. All new admissions and newly identified residents with weight loss will be communicated with Registered Dietician by the Food Service Director.	

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F 325	Continued From page 85 copy of a Medication Error Report form. She indicated the facility had identified multiple medication errors and had completed Medication Error Report forms on each error that had been identified. She revealed she had a "stack" of Medication Error Reports. She reported she had forgotten about this medication error for Resident #81 when she was interviewed earlier this day (2/28/17 at 12:18 PM). The form indicated a medication error was identified for Resident #117 on 1/17/17. Resident #117 was noted to have not received Remeron or Resource from 1/1/17 through 1/16/17 due to a transcription error on the MAR. The form revealed Resident #117 had a poor appetite and continued to lose weight. The DON indicated when the MARs for Resident #117 were transcribed from December 2016 to January 2017 the Remeron and Resource had been mistakenly omitted and the error was not identified until 1/17/17. She stated at the time of the error the MARs were transcribed by floor nurses and were not reviewed by Administrative Nurses. She indicated the Administrative Nurses had since been assisting with monthly MAR checks. A phone interview was conducted with the RD on 2/28/17 at 4:00 PM. She indicated she was familiar with Resident #117. The physician's order dated 12/21/16 for Remeron 7.5mg once daily at bed time and Resource 90 ml three times daily for Resident #117 were reviewed with the RD. The medication error report dated 1/17/17 that indicated Resident #117 had not received the ordered Remeron or Resource from 1/1/17 through 1/16/17 was reviewed with the RD. She indicated she had not been made aware of the error. She indicated she expected to be informed of those types of errors.	F 325	An audit will be completed by 4/13/17, by a nurse manager, of resident's with orders for Remeron and supplements to ensure they are being given as ordered. Audit will be completed monthly for three (3) months. The QAPI Committee will review audit results for compliance monthly for three (3) months in the monthly QAPI meeting to assure compliance is sustained. Will re-evaluate for compliance for compliance and if compliance is not met will continue for another three (3) months. The Food Service Director will bring significant weight change report to QAPI meeting monthly.	

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A follow up interview was conducted with the DON on 3/2/17 at 10:40 AM. She indicated her expectation was for physician's orders to be followed.
2. Resident #87 was admitted to the facility 7/7/15. Cumulative diagnoses included dementia without behavioral disturbance, depression and low potassium level in January 2017.

A Quarterly Minimum Data Set (MDS) dated 12/13/16 indicated Resident #87 was severely impaired in cognition. She required supervision with eating. Weight documented during the assessment period was 121 pounds with no weight loss or gain.

A nutritional assessment dated 12/13/16 indicated Resident #87 weighed 121.4 pounds on 12/4/16. There was no decrease in food intake and no weight loss was noted. Resident #87 was within a normal nutritional status.

A nutrition note by the Dietary Manager dated 12/13/16 at 1:20PM stated Resident #87's current weight was 121.4 pounds. Her diet remained no added salt/ double portions. Resident #87 fed herself and might require set up assistance. Weight was down 1.14% in one month, down 3.19% in three months, down 8.31% in six months. Resident was doing well with no problems at this time and had a BMI (body mass index) of 22. Continue to monitor.

A care plan dated 7/6/16 and last reviewed 1/2/17 indicated Resident #87 was on a therapeutic diet. Additions to the problem dated 11/2/16 stated weight loss due to depression. Goals were to be compliant with diet order next 90 days and

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Resident #87 would not have significant weight loss. Approaches included diet as ordered. Offer equivalent substitute if needed. Monthly/ weekly weight as appropriate. Monitor percentage eaten and record. Encourage adequate intake and compliance. Dietary consult. Notify family/ physician of change of status. Monitor for signs and symptoms of dehydration. Interventions added on 12/28/16 was protein supplement three times daily for nutritional support and on 1/2/17 protein rich foods.

A nursing note dated 1/12/17 indicated Resident #87 had to be encouraged a great deal to take her medicine every day and ate very little of her diet.

Physician orders for February 2017 revealed a diet order for regular no added salt diet with potassium rich foods. House supplement powder (protein powder) in 8 ounces of water three times daily after eating (9:00AM, 1:00PM and 5:00PM) with the original physician order dated 7/24/15. Protein powder 1 scoop in 4 ounces of fluid three times daily for supplement (8:00AM, 12 noon and 4:00PM) with the original physician order dated 12/28/16. There was not a physician's order for super foods or for double portions.

A Registered Dietician's (RD) note dated 2/16/17 at 5:40PM stated Resident #87 was on a no added salt diet. She received protein powder 1 scoop three times daily and super foods. Intake was noted at 50-75% and she accepted bedtime snacks. Weight was documented at 116.2 pounds with a weight loss of 11.97 percent during the last 6 months. Potential for variance in weight might be due to hypothyroidism. The RD made no new recommendations to address Resident

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#87's continued weight loss.

A review of Resident #87's weights from August 2016 through February 2017 revealed the following: 8/7/16-132 pounds; 9/28/16--125.4 pounds; 10/1/16--124.6 pounds; 11/5/16--122.8 pounds; 12/4/16--121.4 pounds; 1/1/17--118.2 pounds and 2/5/17--116.2 pounds. This represented a 11.97 percent weight loss from 8/7/16 through 2/5/17.

The January 2017 Personal Care Record for Resident #87 revealed she usually consumed 50-100% of breakfast, 0-25% of lunch and dinner. Snacks were consistently documented as refused in January.

The February 2017 Personal Care Record for Resident #87 revealed she usually consumed 50-100% of breakfast and dinner and usually consumed 0-25% of lunch. Bedtime snacks were usually refused.

On 2/28/17 at 12:40PM, an observation was conducted during the lunch meal. Resident #87 was feeding herself and consumed 100% of the protein supplement and approximately 75 percent of a grilled cheese sandwich. Resident #87 had green beans for a vegetable and consumed very few bites.

On 2/28/17 at 12:40PM, Nurse #3 stated Resident #87 liked grilled cheese sandwiches and also usually ate only pancakes for breakfast.

On 2/28/2017 at 4:59PM, an interview was conducted with the Dietary Manager. The Dietary Manager stated Resident #87 received super

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foods at meals which consisted of foods such as oatmeal (add brown sugar, fortified milk for extra calories) and/or fortified mashed potatoes at each meal. She said she was not aware that Resident #87 should have potassium rich foods as ordered by the physician 1/2/17 and said the resident's tray card indicated regular diet/ super foods. The Dietary Manager stated Resident #87 was still at a good weight and that was why there were no changes to Resident #87's diet in December 2016.

On 2/28/17 at 4:59PM, the Dietary Manager reviewed Resident #87's diet slip that stated her current diet was no added salt with super foods. When asked why Resident #87 did not receive any super foods or potassium rich foods for the lunch meal of 2/28/17, she stated Resident #87 should have received fortified mashed potatoes for the super food. She was unaware that she should have potassium rich foods.

On 3/1/17 at 10:10AM, an interview was conducted with Physician #2. The physician reviewed her notes and stated she had noted weight loss for Resident #87 on 2/14/17 but had not implemented anything to prevent further weight loss. The physician said she must have just missed it. She stated she would order Marinol or Remeron to increase the resident's appetite and would order a liquid house supplement.

On 03/01/2017 at 10:28 AM, an interview was conducted with the Registered Dietician (RD). She stated Resident #87 received super foods at meals and she noted the resident's meal intake averaged 50-75% when she reviewed the chart on 2/16/17. The RD stated when she assessing

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F 325	Continued From page 90 Resident #87's nutritional status and weight loss on 2/16/17, she reviewed the resident's weekly skilled nursing summary to determine the resident's average meal consumption which indicated Resident #87 consumed 75% of meals and 100% of snacks. The RD stated she did not review the resident's Personal Care Record for meal consumption, which was completed by the nursing assistants, and reflected that Resident #87 consumed less of her meals than what was documented the resident's weekly skilled nursing summary. The RD stated she would have put something else in place on 2/16/17 to address Resident #87's weight loss and prevent further weight loss if she had known the resident was eating less at meals than what was documented on the resident's weekly skilled nursing summary.	F 325		
F 329 SS=E	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or	F 329		4/14/17

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F 329	Continued From page 91 (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to obtain laboratory values to monitor the use of a statin medication for 1 (Residents #39) of 5 sampled residents reviewed for unnecessary drugs. Findings included: 1. Resident #39 was admitted to the facility on 8/15/15. Cumulative diagnoses included hypercholesterolemia. An annual Minimum Data Set dated 11/24/16 indicated Resident #39 was cognitively intact. A review of physician orders for February 2017 revealed an order for atorvastatin calcium (cholesterol lowering medication) 20 milligrams by mouth every night. Medical record review revealed there were no laboratory results for a lipid panel or liver panel	F 329	F329 Drug Regimen Resident #39: Upon reviewing of medical record by the Consultant Pharmacist and the Staff Development Coordinator, lab results were found for a general chemistry profile that included liver function results as well. This was completed 10/4/16, therefore no new liver function panel was ordered. A Lipid panel was drawn 3/24/17 and indicated the following results: Cholesterol 134 Normal Range 0 -199 Triglycerides 177 (H) 0 -149 HDL-Cholesterol 38.4 (L) 40-60 LDL-Calculated 60 0 -99	

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F 329	Continued From page 92 since admission to the facility 8/15/15. (These are laboratory tests completed for the monitoring of cholesterol lowering medication.) A review of the monthly pharmacy consultant reviews revealed no recommendations for laboratory monitoring for the use of the atorvastatin calcium. On 2/28/2017 at 4:25 PM, an interview was conducted with the Director of Nursing who stated the last lipid panel was in 2015. She said they had changed the pharmacy consultant and his first visit was in February. She reviewed the recommendations and said there was not a recommendation for resident. On 3/1/17 at 1:05PM, an interview was conducted with Physician #1. He stated Resident #39 should have at least a yearly lab for cholesterol and liver panel. Physician #1 said he relied on the pharmacy consultant to help him remember the monitoring by writing recommendations. He said he had not received any pharmacy recommendations that Resident had not had any monitoring labs since 2015.	F 329	VLDL 35 6-40 All residents with cholesterol lowering medications have had a lipid panel performed in the last 12 months or was completed by 4/6/17 as noted by the pharmacist and Staff Development Coordinator. All residents receiving cholesterol lowering medications will have a lipid panel performed annually. A file has been developed to alert Unit Managers and Director of Nursing (DON) when labs are due for each resident, which includes those with cholesterol lowering medications so that lipid panels are done annually. Consultant Pharmacist will review medical record of same residents and ensure cholesterol lowering medications have been monitored. Consultant Pharmacist visited on 3/27 & 3/28/17. He reviewed all resident's charts with cholesterol lowering medications, monitoring dosages and labs present or needed. Consultant Pharmacist will review medical record of residents with cholesterol lowering medications to ensure this class of medications have been monitored as evidenced by lab results. This was done on 3/27 & 3/28/17. He will continue this as part of his routine monthly review. All new admission and re-admissions will be reviewed for cholesterol lowering medication monitoring by the DON and/or Assistant Director of Nursing and/or the Staff Development Coordinator. Current residents with new cholesterol	

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F 329	Continued From page 93	F 329	lowering medications ordered will be reviewed to ensure lab monitoring is in place. They will be added to the file that alerts Unit Managers and the DON to upcoming labs when orders are reviewed in Morning Meeting by the DON and Unit Manager/ Staff Development Coordinator. The QAPI Committee will review Consultant Pharmacist report brought by the Consultant Pharmacist or DON for compliance monthly for three (3) months in the monthly QAPI meeting to assure compliance is sustained. Will re-evaluate for compliance for compliance and if compliance is not met will continue for another three (3) months.	
F 333 SS=D	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and physician interview, the facility failed to follow the physician's order for Coumadin (anticoagulant medication) resulting in 11 administrations of a higher dose than ordered for 1 of 5 residents (Resident #81) reviewed for unnecessary medications. The facility also failed to follow the physician's order for Ativan (antianxiety medication) resulting in 9 administrations of a higher dose than ordered for 1 of 3 sampled residents (Resident #87) reviewed for complete	F 333	F333 Medication Errors Resident #81, Coumadin is being administered as ordered. Review was done by the Director of Nursing (DON) and Nurse Consultant, of the Medication Administration Record (MAR) and current orders on 3/6/17. Resident #81's physician orders have been reviewed to ensure they are current and accurate. Review was done by the Director of Nursing (DON) and Nurse	4/14/17

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F 333	Continued From page 94 and accurate medical records. The findings included: 1. Resident #81 was initially admitted to the facility on 6/29/11 and most recently readmitted on 7/23/16 with diagnoses that included heart disease. The plan of care for Resident #81 included the need/problem area of anticoagulant drug use. This need/problem area was initiated on Resident #81's care plan on 9/20/16. The interventions included the administration of medications as ordered for Resident #81. A physician's order dated 11/25/16 indicated Coumadin (anticoagulant medication) 9.5 milligrams (mg) once daily at bed time for Resident #81. The annual Minimum Data Set (MDS) assessment dated 12/6/16 indicated Resident #81 had moderate cognitive impairment. He was indicated to have received anticoagulant medication on 7 of 7 days during the MDS review period. Laboratory results dated 12/6/16 indicated Resident #81's PT/INR (Prothrombin Time/International Normalized Ratio), a test used to monitor the effectiveness of anticoagulant medication, was outside of the normal limits. Resident #81's PT was indicated as high at 37.2 (normal range of 10.7-13.4) and his INR was also high at 3.03 (normal range of 0.89-1.11). The laboratory results indicated the physician was notified on 12/7/16 of Resident #81's PT/INR results and new physician's orders were received.	F 333	Consultant, of the Medication Administration Record (MAR) and current orders on 3/6/17. Resident #81's MARs have been reviewed to ensure current does is being given as ordered. Review was done by the Director of Nursing (DON) and Nurse Consultant, of the Medication Administration Record (MAR) and current orders on 3/6/17. Resident #87 Ativan is being administered as ordered Review was done by the DON of MAR and current physician's order on 3/6/17. Resident #87's physician orders have been reviewed to ensure current and accurate. Review was done by the DON of MAR and current physician's order on 3/6/17. Resident #87's MARs have been reviewed to ensure current does is being given as ordered. Review was done by the DON of MAR and current physician's order on 3/6/17. Resident #87's is accurate as of March 6, 2017 as reviewed by the DON. All nurses will be educated on importance of documenting narcotic pain medications on MAR as well as maintenance the narcotic count sheet accurately by 4/14/2017. Narcotic Audit sheet for each resident has been placed in resident's MAR to ensure medications are documented as given. On coming and off going staff nurse will sign that documentation is complete at each change of shift. The Coumadin Audit tracking tool was initiated on December 22, 2016 to monitor	

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F 333	Continued From page 95 A physician's order dated 12/7/16 indicated to hold Resident #81's Coumadin (9.5mg) that evening (12/7/16) and then start Coumadin 9mg daily on 12/8/16. A physician's order dated 12/19/16 indicated "Draw PT/INR now" for Resident #81. A follow up physician's order was written on 12/19/16 that indicated a discontinuation of the previous Coumadin order and the start of Coumadin 9.5mg for Resident #81. A review of the December 2016 Medication Administration Record (MAR) for Resident #81 indicated he was administered 9.5mg of Coumadin once daily at bed time from 12/1/16 through 12/6/16 as ordered. On 12/7/16 the physician's order to hold Coumadin was followed for Resident #81. Further review of the MAR revealed on 12/8/16 through 12/18/16 Resident #81 was administered 9.5mg of Coumadin once daily at bed time instead of Coumadin 9mg once daily as ordered by the physician on 12/7/16. This resulted in 11 administrations of a higher dose of Coumadin than ordered for Resident #81. An interview was conducted with the Director of Nursing (DON) on 2/28/17 at 2:20 PM. She indicated the facility had identified multiple medication errors and had completed Medication Error Report forms on each error that had been identified. She stated she had a "stack" of Medication Error Reports. On 2/28/17 at 2:30 PM the DON provided a Medication Error Report for Resident #81. The form indicated a medication error was identified for Resident #81 on 12/19/16. Resident #81 was noted to have been administered the incorrect	F 333	Coumadin administration as ordered in response to the medication error cited on December 19, 2016. This tool is maintained by the DON. 11pm to 7am and 7pm -7am nurses will be in-serviced on completing chart checks each evening by 4/14/2017 by the Nurse Consultant or the Corporate Clinical Nurse. All nurses will be in-serviced on the correct procedure in transcribing physician orders by 4/14/2017. MARs for the upcoming month will be double checked by administrative nurses against current monthly MARs. Narcotic Audit sheet for each resident has been placed in resident's MAR will be reviewed daily Monday through Friday by 11p-7a Charge Nurse, Narcotic Audit Sheets for Saturday and Sunday will be included with the audit done on Monday, for one month then weekly for one month, weekly x 2 for one month. Charge nurse will give completed audits with summary to the DON weekly on Fridays. a. The Coumadin Audit tracking tool is monitored by the Director of Nurse daily Monday through Friday. Orders and changes received Saturday and Sunday will be updated to the log on Monday. Any orders initiating and change or new order will be transcribed by the staff nurse receiving order to include correct transcription to the MAR and lab requested completed as needed. An audit of all residents receiving Coumadin will be completed to verify no medication errors by 4/13/17.	

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F 333	Continued From page 96 dosage of Coumadin from 12/8/16 through 12/18/16 due to a transcription error on the MAR. The form indicated no harm or adverse reaction occurred for Resident #81. The form had a section that indicated the measures that were taken to prevent the reoccurrence of similar errors. This section had not been completed. An interview was conducted with Resident #81's physician on 3/1/17 at 10:02 AM. The Medication Error Report dated 12/19/16 for Resident #81 was reviewed with the physician. She indicated she had been made aware of the error on 12/19/16 and she ordered a PT/INR for Resident #81 when she was informed. She reported that after assessing Resident #81's PT/INR results from 12/19/16 she felt he had not been caused any harm by the error. She revealed it was a concern to her that her order for Resident #81 dated 12/7/16 for Coumadin 9mg starting on 12/8/16 had not been followed. The physician indicated it was her expectation for her orders to be followed. An interview was conducted with the DON on 3/2/17 at 10:40 AM. She indicated her expectation was for physician ' s orders to be followed. 2. Resident #87 was admitted to the facility on 7/7/15. Cumulative diagnoses included dementia without behavioral disturbance and depression. A Quarterly Minimum Data Set (MDS) dated 12/13/16 indicated Resident #87 was severely impaired in cognition. A physician's order dated 12/19/16 revealed an	F 333	The QAPI Committee will review results of the Narcotic Audit and the Coumadin Audit for compliance monthly for three (3) months in the monthly QAPI meeting to assure compliance is sustained. Will re-evaluate for compliance for compliance and if compliance is not met will continue for another three (3) months. Audits will be brought to the QAPI Committee meeting by the DON.	

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F 333	Continued From page 97	F 333		

order for Ativan (anti-anxiety medication) 0.25 milligrams by mouth daily. Discontinue Ativan 0.5 milligrams by mouth twice daily.

A review of the Control drug reconciliation sheet revealed Ativan 0.25 milligrams was administered two times daily on 12/19/16, 12/20/16, 12/21/16, 12/22/16, 12/23/16, 12/25/16, 12/26/16, 12/27/16 and 12/28/16.
Nursing notes were reviewed for December 2016 and there was no documentation that Resident #87 had any adverse effects from medication.

On 3/1/17 at 10:15AM, an interview was conducted with Physician #2. She stated she had been informed by one of the facility staff that Resident #87 had received two doses of Ativan daily instead of one dose as ordered. The physician said she thought Resident #87 became more somnolent possibly due to the added dose and she expected staff to follow physician orders.

On 3/2/17 at 8:30AM, an interview was conducted with the MDS Coordinator who stated she was doing the end of the month reconciliation of physician orders and Medication Administration Records (MAR) from December to January when she found that Resident #87 had received Ativan in the evening as well as on day shift. She said the nurse who administered the evening medication no longer worked at the facility.

On 3/02/17 at 10:13AM, an interview was conducted with the Director of Nursing who stated the nurse should have administered the medications by reading the MAR that had the correct dosage documented on 12/19/16 and not giving medications by memory.

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F 333	Continued From page 98 On 3/3/17 at 1:03PM, a telephone interview was conducted with Nurse #5 who was no longer employed at the facility. She stated she had not seen the order for the medication change and had not looked in the medical record.	F 333		
F 354 SS=D	483.35(b)(1)-(3) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON (1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. (2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. (3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews, the facility failed to use the services of a Registered Nurse (RN), other than the Director of Nursing (DON) or the Minimum Data Set RN (MDS), for 8 consecutive hours daily with an average daily census of 79 residents for 38 of 59 days reviewed (1/1/17 through 2/28/17) Findings included: A review of the Weekday Nursing Assignment sheets for January 1, 2017 to January 1, 2017 indicated the following: On Monday 1/2/17, the MDS nurse was listed as the RN coverage.	F 354	F354 RN Waiver The facility is using the services of a registered nurse for at least eight (8) consecutive hours seven days a week. The Administrator will receive the staffing sheet for the next day with the name of the RN providing RN coverage. The Administrator will then give the sheet to the Human Resource Director (HR). HR will verify that the RN named did provide 8 hours of coverage on the assigned day by checking Time Tender. An audit will be completed daily to reflect the required registered nurse coverage. Audit will be done daily by Human	4/14/17

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F 354	Continued From page 99 On Wednesday 1/4/17, the MDS nurse was listed as the RN coverage. On Thursday 1/5/17, the MDS nurse was listed as the RN coverage. On Friday 1/6/17, the MDS nurse was listed as the RN coverage. On Monday 1/9/17, the MDS nurse was listed as the RN coverage. On Tuesday 1/10/17, the MDS nurse was listed as the RN coverage. On Wednesday 1/11/17, the MDS nurse was listed as the RN coverage. On Thursday 1/12/17, the MDS nurse was listed and the RN coverage. On Friday 1/13/17, the MDS nurse was listed as the RN coverage. On Monday 1/16/17, the MDS nurse was listed as the RN coverage. On Wednesday 1/18/17, the MDS nurse was listed as the RN coverage. On Thursday 1/19/17, there was no RN coverage listed for 24 hours. On Monday 1/23/17, the MDS nurse was listed as the RN coverage. On Tuesday 1/24/17, the MDS was listed as the RN coverage. On Wednesday 1/25/17, there was no RN coverage listed for 24 hours. A review of the Weekend Nursing Assignment Sheets for January 1, 2017 to January 21.2017 indicated the following: On Saturday 1/28/17, there was no RN coverage listed for 24 hours. A review of the Weekday Nursing Assignment sheets for January 1, 2017 to January 31, 2017 indicated the following: On Tuesday 1/31/17, there was no RN coverage listed for 24 hours.	F 354	Resources or Administrator by reviewing time tender and comparing with the staff sign in sheet. Nursing schedule is currently managed by the Director of Nursing (DON) with the Staff Development Coordinator. They review staffing daily for each shift to ensure that there is eight (8) hour coverage by an RN. An audit will be completed daily to reflect the required registered nurse coverage by Human Resources, Administrator and/or Director of Nursing (DON) daily for four weeks, bi-weekly for one month, and monthly for one month. The QAPI Committee will review results of the Registered Nurse Audit for compliance monthly for three (3) months in the monthly QAPI meeting to assure compliance is sustained. Will re-evaluate for compliance for compliance and if compliance is not met will continue for another three (3) months. Audit will be brought to the QAPI Committee by Human Resource Director	

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A review of the Daily Staffing Sheet for January 1, 2017 to January 31, 2017 indicated the lowest census of 77 for the month.

A review of the Weekday Nursing Assignment sheets for February 1, 2017 to February 28, 2017 indicated the following:

On Wednesday 2/1/17, there was no RN coverage listed for 24 hours.
On Thursday 2/2/17, there was no RN coverage listed for 24 hours
On Friday 2/3/17, there was no RN coverage listed for 24 hours.
On Monday 2/6/17, there was no RN coverage listed for 24 hours.
On Tuesday 2/7/17, there was no RN coverage listed for 24 hours.
On Wednesday 2/8/17, there was no RN coverage listed for 24 hours.
On Thursday 2/9/17, there was no RN coverage listed for 24 hours.
On Friday 2/10/17, there was no RN coverage listed for 24 hours.
On Monday 2/13/17, there was no RN coverage listed for 24 hours.
On Tuesday 2/14/17, there was no RN coverage listed for 24 hours.
On Wednesday 2/15/17, there was no RN coverage listed for 24 hours.
On Thursday 2/16/17, there was no RN coverage listed for 24 hours.
On Friday 2/17/17, there was no RN coverage listed for 24 hours.

A review of the Weekend Nursing Assignment

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F 354	Continued From page 101 Sheets for February 1, 2017 to February 28, 2017 indicated the following: On Saturday 2/18/17, there was RN coverage listed for 4 hours in a 24 hour period. On Sunday 2/19/17, there was RN coverage listed for 4 hours in a 24 hour period. A review of the Weekday Nursing Assignment sheets for February 1, 2017 to February 28, 2017 indicated the On Monday 2/20/17, there was no RN coverage listed for 24 hours. On Tuesday 2/21/17, there was no RN coverage listed for 24 hours. On Wednesday 2/22/17, there was no RN coverage listed for 24 hours. On Thursday 2/23/17, there was no RN coverage listed for 24 hours. On Monday 2/27/17, the schedule read the DON was on 200 hall cart for first shift. On Tuesday, 2/28/17, there was no RN coverage listed for 24 hours. A review of the Daily Staffing Sheet for February 1, 2017 to February 28, 2017 indicated the lowest census of 81 for the month. A review of the RN time punches for 2/1/17 to 2/28/17 revealed the following: On Wednesday 2/1/17, no RN punched the time clock for 24 hours On Thursday 2/2/17, an RN was punched in for 6 hours and 15 minutes. On Friday 2/3/17, no RN punched the time clock	F 354		

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for 24 hours.
On Monday 2/6/17, no RN punched the time clock for 24 hours.
On Thursday 2/16/17, no RN punched the time clock for 24 hours.
On Friday 2/17/17, no RN punched the time clock for 24 hours.
On Saturday 2/18/17, an RN was punched in for 3 hours and 30 minutes.
On Sunday, 2/19/17, an RN was punched in for 3 hours and 45 minutes.
On Monday 2/20/17, no RN punched the time clock for 24 hours.
On Tuesday, 2/21/17, an RN was punched in for 3 hour and 30 minutes.
On Wednesday 2/22/17, no RN punched the time clock for 24 hours.
On Thursday 2/23/17, no RN punched the time clock for 24 hours.
On Tuesday, 2/28/17, no RN punched the time clock for 24 hours.

In an interview on 2/28/17 at 3:10 PM, the MDS nurse stated she took over as the MDS nurse on 2/20/17 when the previous MDS resigned. She confirmed she was a licensed practical nurse (LPN).

In an interview on 3/2/17 at 8:40 AM, the scheduling coordinator stated she took over the schedule about three weeks ago. She stated the DON told her that she could count the DON or the MDS nurse hours to meet the required 8 hours of consecutive RN coverage. She stated she was confused because one minute the DON stated she could count her as the RN coverage and the next minute she was told the DON could not count as the required RN coverage.

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F 354	Continued From page 103 In an interview on 3/2/17 at 8:50 AM the business office manager stated she was the previous scheduling coordinator up until 1/9/17. She stated she was told by the DON she could count the DON as RN coverage in an emergency. The business office manager stated she was aware there had to be 8 hours of consecutive RN coverage 7 days a week and the DON or the MDS nurse could not count as the RN coverage in a building with more than 60 residents. She said this practice of counting the DON or the MDS nurse had been going on for a long time. In an interview on 3/2/17 at 9:30 AM, the DON stated it was her understanding that she could serve as the charge nurse in an emergency situation but it was her expectation that the scheduling coordinator was responsible to staff additional RN coverage.	F 354		
F 428 SS=E	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic.	F 428		4/14/17

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F 428	Continued From page 104 (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, Physician and Pharmacy Consultant interview, the Pharmacy Consultant failed to address the need to monitor the lipid level and liver function for a resident on a cholesterol lowering medication (Resident #39)	F 428	F428 Drug Regimen Review Resident #39: Upon reviewing of medical record by the Consultant Pharmacist and the Staff Development Coordinator, lab results were found for a general chemistry	

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F 428	Continued From page 105	F 428		

for one of five sampled residents reviewed for unnecessary medications. The findings included:

Resident #39 was admitted to the facility on 8/15/15. Cumulative diagnoses included hypercholesterolemia. An annual Minimum Data Set dated 11/24/16 indicated Resident #39 was cognitively intact.

A review of physician orders for February 2017 revealed an order for atorvastatin calcium (cholesterol lowering medication) 20 milligrams by mouth every night. The atorvastatin calcium was originally ordered 10/20/15 and Resident #39 had received the medication since that date.

Medical record review revealed there were no laboratory results for a lipid panel or liver panel (both are tests to determine liver damage which can occur with the use of cholesterol lowering medication) since admission to the facility 8/15/15.

The monthly Pharmacy Consultant reviews from 6/14/16 through 2/21/17 revealed no recommendations for laboratory monitoring for the use of the atorvastatin calcium.

On 2/28/2017 at 4:25PM, an interview was conducted with the Director of Nursing who stated the last lipid panel for Resident #39 was in 2015. She said they had changed Pharmacy Consultants and his first visit was in February. She reviewed the recommendations from the Pharmacy Consultant on 2/21/17 and said there was not a recommendation for Resident #39 to have liver function monitoring tests.

On 3/1/17 at 1:05PM, an interview was conducted

profile that included liver function results as well. This was completed 10/4/16, therefore no new liver function panel was ordered. A Lipid panel was drawn 3/24/17 and indicated the following results:

Cholesterol	134	Normal Range	0-199
Triglycerides	177 (H)		0-149
HDL-Cholesterol	38.4 (L)		40-60
LDL-Calculated	60		0-99
VLDL	35		6-40

All residents with cholesterol lowering medications have had a lipid panel performed in the last 12 months or was completed by 4/6/17 as noted by the pharmacist and Staff Development Coordinator. These residents will also have a liver panel performed by 4/13/17 if one has not been completed within the last 12 months.
All residents receiving cholesterol lowering medications will have a lipid panel and a liver panel performed annually. A file has been developed to alert Unit Managers and Director of Nursing (DON) when labs are due for each resident, which includes those with cholesterol lowering medications so that lipid and liver panels are done annually.
Consultant Pharmacist will review medical record of same residents and ensure cholesterol lowering medications have been monitored. Consultant Pharmacist visited on 3/27 & 3/28/17. He reviewed all resident's charts with

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F 428	Continued From page 106 with Physician #1. He stated Resident #39 should have at least a yearly lab tests for cholesterol and liver panel. Physician #1 said he relied on the Pharmacy Consultant to help him remember the monitoring by writing recommendations. He said he had not received any pharmacy recommendations that Resident #39 had not had any liver function monitoring labs since 2015. On 3/02/2017 at 11:57AM, an interview was conducted with the Pharmacy Consultant. He stated his review included a review of the medications and what type of monitoring had been done with the medications. From his understanding and what he had been told, there had not been many recommendations completed in the past. The Pharmacy Consultant said he tried to do as many recommendations as he could when he came in February without overwhelming the facility. He reviewed Resident #39's recommendations and said he had written a recommendation regarding the use of the Ambien. He had not addressed the atorvastatin calcium and did not know the last time Resident #39 had a fasting lipid panel done. A lipid panel and ALT (alanine aminotransferase-test used to detect liver injury) should be done at least yearly.	F 428	cholesterol lowering medications, monitoring dosages and labs present or needed. Consultant Pharmacist will review medical record of residents with cholesterol lowering medications to ensure this class of medications have been monitored as evidenced by lab results. This was done on 3/27 & 3/28/17. He will continue this as part of his routine monthly review. All new admission and re-admissions will be reviewed for cholesterol lowering medication monitoring by the DON and/or Assistant Director of Nursing and/or the Staff Development Coordinator. Current residents with new cholesterol lowering medications ordered will be reviewed to ensure lab monitoring is in place. They will be added to the file that alerts Unit Managers and the DON to upcoming labs when orders are reviewed in Morning Meeting by the DON and Unit Manager/ Staff Development Coordinator. The QAPI Committee will review Consultant Pharmacist report brought by the Consultant Pharmacist or DON for compliance monthly for three (3) months in the monthly QAPI meeting to assure compliance is sustained. Will re-evaluate for compliance for compliance and if compliance is not met will continue for another three (3) months.	
F 514 SS=E	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional	F 514		4/14/17

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F 514	Continued From page 107 standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and pharmacy and facility staff interview, the facility failed to maintain a complete and accurate medical records as evidenced by medications signed off from the narcotic count were not documented as administered on the resident's Medication Administration Record (MAR) consistently for 3	F 514	F514 Complete/Accurate Records Resident #72 physician orders have been reviewed to ensure pain medications ordered are current and accurate. Review was done by the DON of MAR and current physician□s order on 3/6/17. Resident #72 MAR and narcotic count	

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F 514	Continued From page 108 (Residents #125, #72 & #87) of 5 sampled residents reviewed for complete and accurate clinical records. Findings included: 1. Resident # 72 was admitted to the facility on 8/6/16 with multiple diagnoses including spondylosis with myelopathy (degenerative joint disease) of cervical region. The quarterly Minimum Data Set (MDS) assessment dated 1/14/17 indicated that Resident #72 had moderate cognitive impairment and she had received scheduled and as needed (PRN) pain medication. Resident #72's physician's orders for January 2017 was reviewed. The orders included Norco (narcotic pain medication) 5/325 milligrams (mgs.) 2 tablets by mouth daily at 6 AM and 1 tablet every 4 hours as needed for pain. Review of the narcotic count and MARs for January and February 2017 was conducted. The following dates were noted to have discrepancies between the narcotic count and the MAR: January 7 & 8 - Norco was signed off 4 times from the narcotic count and was documented 3 times on the MAR January 13- Norco was signed off 5 times from the narcotic count and was documented 4 times on the MAR January 17 - Norco was signed off 2 times from the narcotic count and was documented once on the MAR January 18, February 2, February 6, February 17, February 21 and February 26 - Norco was signed off 3 times from the narcotic count and was documented 2 times on the MAR January 19- Norco was signed off 6 times from	F 514	sheet have been reviewed to ensure consistency in documentation. Review was done by the DON of MAR and current physician□s order on 3/6/17. #125 was discharged on 2/21/17. Closed chart review was done 4/6/17 by Clinical Nurse Consultant. physician orders, MAR and nurses□ notes were reviewed. Resident received medication as ordered. Resident reported medication effective. Resident #125 narcotic count sheet have been reviewed to ensure consistency in documentation. It was accurate. Resident #72 physician orders for Ativan have been reviewed to ensure ordered are current and accurate Review was done by the DON of MAR and current physician□s order on 3/6/17. Resident #72 MAR and narcotic count sheet have been reviewed to ensure consistency in documentation. Review was done by the DON of MAR and current physician□s order on 3/6/17. Resident #87□s Ativan is being administered as ordered Review was done by the DON of MAR and current physician□s order on 3/6/17. Resident #87□s physician orders have been reviewed to ensure current and accurate. Review was done by the DON of MAR and current physician□s order on 3/6/17. Resident #87□s MARs have been reviewed to ensure current does is being given as ordered. Review was done by the DON of MAR and current physician□s order on 3/6/17. Resident #87□s is accurate as of March 3, 2017 as reviewed by the DON.	

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F 514	Continued From page 109 the narcotic count and no documentation on the MAR that Norco was administered. January 21, January 27, February 7, February 13, February 24- Norco was signed off 4 times from the narcotic count and was documented 3 times on the MAR. January 22 - Norco was signed off 5 times from the narcotic count and was documented 4 times on the MAR. January 25 & February 4 - Norco was signed off 5 times from the narcotic count and was documented 3 times on the MAR. January 28, January 29, February 11, February 12 & February 18 - Norco was signed off 5 times form the narcotic count and was documented 2 times on the MAR. February 5, Norco was signed off 4 times from the narcotic count and was documented 1 time on the MAR. February 10 - Norco was signed off 3 times from the narcotic count and was documented on the MAR one time. February 19, Norco was signed off 4 times from the narcotic count and was documented 2 times on the MAR. February 27-Norco was signed off 4 times from the narcotic count and was documented 3 times on the MAR. On 3/1/17 at 5:20 PM, Nurse # 4 was interviewed. Nurse #4 stated that she tried to remember to document the narcotics after administration but at times she had tendency to forget. On 3/2/17 at 10:15 AM, the Director of Nursing was interviewed. The DON stated that she expected the nurses to document narcotics on the MARs when administered. She also indicated that the unit manager was responsible for	F 514	The Director of Nursing (DON) or Staff Development Coordinator has reviewed all residents narcotics MAR comparing to resident s narcotic sheet to documentation. Review will be completed by 4/14/17. All nurses will be in-serviced on the importance of documenting narcotic administration in the MAR and maintaining an accurate narcotic count by Pharmacy Nurse Representative, DON, and Nurse Consultants. In-service will be complete on 4/12/2017. A Narcotic Audit Sheet for each applicable resident will be placed in residents MAR to ensure accuracy of documentation of narcotic medications given as ordered. Director of Nursing or Unit Manager will monitor a minimum of 15 narcotic count sheets and compare with MAR weekly for 4 (4) weeks, twice a month for 1 month, and then one time a month for one month to ensure consistency of documentation. The QAPI Committee will review of MAR Narcotic monitoring for compliance monthly for three (3) months in the monthly QAPI meeting to assure compliance is sustained. Will re-evaluate for compliance for compliance and if compliance is not met will continue for another three (3) months. Audit results will be brought to QAPI Committee meeting by the DON	

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F 514	Continued From page 110	F 514		

monitoring the nurses' documentation but the unit manager was working on the floor most of the time so nobody had been monitoring the nurses' documentation.

On 3/2/17 at 3:45 PM, the Pharmacist was interviewed. The Pharmacist stated that on 2/8/17, a nurse from the pharmacy came to the facility to do an audit of the medication cart including the narcotics. The pharmacist indicated that the report from that visit was given to the DON.

On 3/2/17 at 3:50 PM, the DON shared the report from the audit that was conducted on 2/8/17 by the nurse from the pharmacy. The report included issues with controlled medications being signed off and not documented on the resident's MAR as administered.

On 3/3/17 at 11:24 AM, the Staff Development Coordinator (SDC) was interviewed. The SDC identified his initial on the narcotic count and indicated that at times he forgot to document the medication after administration on the resident's MAR.

On 3/3/17 at 11:43 AM, the nurse from the pharmacy was interviewed. The nurse confirmed that she had identified issues that nurses were signing off controlled medications and not documenting on the resident's MAR as administered.

2. Resident # 125 was admitted to the facility on 2/7/17 with multiple diagnoses including L2-L3 decompression/fusion. The admission Minimum

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Data Set (MDS) assessment dated 2/14/17 indicated that Resident #125 ' s cognition was intact and he had had received scheduled and as needed pain medication. The discharge MDS assessment revealed that Resident #125 was discharged to home on

Resident #125 admission doctor ' s order dated 2/7/17 included orders for Oxycodone (narcotic pain medication) 10 mgs 1 tablet by mouth every 12 hours for 14 days and Oxycodone 5 mgs 2-3 tablets by mouth every 4 hours PRN for pain.

On 2/8/17, the order for Oxycodone 10 mgs was changed to 3 times a day PRN and on 2/10/17 the order was changed to Oxycodone 10 mgs by mouth every 8 hours PRN for pain.

Review of the narcotic count and MARs for February 2017 was conducted. The following dates were noted to have discrepancies between the narcotic count and the MAR:
February 14 - Oxycodone was signed off from the narcotic count at 1 PM and was not documented on the MAR as administered.
February 17- Oxycodone was signed off from the narcotic count at 6 AM and 9:15 PM and was not documented on the MAR as administered.
February 18 - Oxycodone was signed off from the narcotic count at 10 PM and was not documented on the MAR as administered.
February 21 - Oxycodone was signed off from the narcotic count at 11:30 AM and was not documented on the MAR as administered.

On 3/1/17 at 5:20 PM, Nurse # 4 was interviewed. Nurse #4 stated that she tried to remember to document the narcotics after administration but at times she had tendency to forget.

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On 3/2/17 at 10:15 AM, the Director of Nursing was interviewed. The DON stated that she expected the nurses to document narcotics on the MARs when administered. She also indicated that the unit manager was responsible for monitoring the nurses ' documentation but the unit manager was working on the floor most of the time so nobody had been monitoring the nurses ' documentation.
On 3/2/17 at 3:45 PM, the Pharmacist was interviewed. The Pharmacist stated that on 2/8/17, a nurse from the pharmacy came to the facility to do an audit of the medication cart including the narcotics. The pharmacist indicated that the report from that visit was given to the DON.
On 3/2/17 at 3:50 PM, the DON shared the report from the audit that was conducted on 2/8/17 by the nurse from the pharmacy. The report included issues with controlled medications being signed off and were not documented on the resident ' s MAR as administered.
On 3/3/17 at 11:24 AM, the Staff Development Coordinator (SDC) was interviewed. The SDC identified his initial on the narcotic count and indicated that at times he forgot to document the medication after administration on the resident ' s MAR.
On 3/3/17 at 11:43 AM, the nurse from the pharmacy was interviewed. The nurse confirmed that she had identified issues that nurses were signing off controlled medications and were not documenting on the resident ' s MAR as administered.

3. Resident #87 was admitted to the facility on 7/7/15. Cumulative diagnoses included dementia without behavioral disturbance and depression.

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A Quarterly Minimum Data Set (MDS) dated 12/13/16 indicated Resident #87 was severely impaired in cognition.

A physician's order dated 12/19/16 revealed an order for Ativan (anti-anxiety medication) 0.25 milligrams by mouth daily. Discontinue Ativan 0.5 milligrams by mouth twice daily.

A review of the Control drug reconciliation sheet revealed Ativan 0.25 milligrams was administered two times daily at 8:00AM and 8:00PM on 12/19/16, 12/20/16, 12/21/16, 12/22/16, 12/23/16, 12/25/16, 12/26/16, 12/27/16 and 12/28/16.

A review of the Medication Administration Record for December 2016 revealed there was no documentation that Ativan 0.25 milligrams had been administered at 8:00PM on 12/19/16, 12/20/16, 12/21/16, 12/22/16, 12/23/16, 12/25/16, 12/26/16, 12/27/16 and 12/28/16. The order on the MAR was transcribed as Ativan 0.5 milligrams. Take 0.5 tab (0.25millilgrmas) by mouth every day at 8:00AM.

On 3/1/17 at 10:15AM, an interview was conducted with Physician #2. She stated she had been informed by one of the facility staff that Resident #87 had received two doses of Ativan daily instead of one dose as ordered. The physician said she thought Resident #87 became more somnolent possibly due to the added dose and she expected staff to follow physician orders.

On 3/2/17 at 8:30AM, an interview was conducted with the MDS Coordinator who stated she was doing the end of the month reconciliation of physician orders and Medication Administration

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F 514	Continued From page 114 Records (MAR) from December to January. She found that Resident #87 had received Ativan in the evening as well as on day shift in comparing the MAR to the orders and the drug reconciliation sheet. She said the nurse who administered the Ativan at 8:00PM no longer worked at the facility. The MDS Coordinator stated the nurse should have documented it on the MAR if she gave the medication and must have given the medication by memory and not checking the MAR and physician orders. On 3/02/2017 at 10:13AM, an interview was conducted with the Director of Nursing who stated the nurse should have administered the medications by reading the MAR and not giving medications by memory. On 3/3/17 at 1:03PM, a telephone interview was conducted with Nurse #5 who no longer was employed at the facility. She stated she had not seen the order for the medication change and had not looked in the medical record. Nurse #5 said something must have been going on or an emergency must have occurred as the reason for not documenting the medication on the MAR.	F 514		
F 520 SS=G	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services;	F 520		4/14/17

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F 520	Continued From page 115 (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review, observations, physician, pharmacy, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the 2/4/16 recertification survey and the 9/23/16 complaint	F 520	F520 ¿¿¿¿ ¿¿ ¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿ ¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿¿ For F157: All occurrence/incident reports will be	

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F 520	Continued From page 116 investigation for 3 recited deficiencies in the areas of services provided as care planned (F282), well-being (F309), and accidents (F323); following the 2/4/16 recertification survey for 5 recited deficiencies in the areas of assessment accuracy (F278), comprehensive care plans (F279), nutrition (F325), unnecessary medications (F329), and complete and accurate clinical records (F514); and following the 11/23/16 complaint investigation for 1 recited deficiency in area of urinary catheter care (F315). These 9 deficiencies were cited again on the current recertification survey of 3/3/17. The continued failure of the facility during 2 or more federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance program. The findings included: This tag is cross referenced to: 1. F278: Assessment Accuracy - Based on record review, observation, and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of pressure ulcer for 1 (Resident #4) of 4 sampled residents reviewed for pressure ulcer and in the area of hospice for 2 (Residents #86 and #81) of 2 sampled residents reviewed for hospice. During the recertification survey of 2/4/16 the facility was cited F278 for failure to accurately code the MDS assessment for medications. On the current recertification survey of 3/3/17 the facility failed to accurately code the MDS assessment in the areas of pressure ulcer and hospice. An interview was conducted with the	F 520	reviewed daily, Monday-Friday, by the Clinical team in the Clinical Morning Meeting. Occurrences that happen Saturday and Sunday will be reviewed in the Morning Meeting on Monday. The Clinical Team consists of the Director of Nursing, Staff Development Coordinator, the Wound Care Nurse and the MDS Coordinator. All Licensed Nurses, including weekend and prn staff, will be in-serviced regarding Notification of Changes to the Physician by the Director Of Nursing (DON) or the Staff Development Coordinator. In-services were started on 3/7/17 and will be completed by 4/7/17. The in-service will include: • Facility Policy for reporting occurrences/changes to physician in a timely manner • Procedure o All accidents/ incident must be reported to department supervisors and incident form completed on the shift that it occurred. o Nurse must complete their part of the incident report completely prior to the end of the shift. o Physician is to be notified of any incident resulting in injury or unusual occurrence after the resident is assessed. Notification must take place prior to the end of shift in which the incident occurred. Document any new orders on a telephone order sheet and transcribe appropriately. A nurses' note is to be made in the medical record stating physician was	

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F 520	Continued From page 117 Administrator on 3/3/17 at 11:45 AM. She indicated she had not worked at the facility during the time of previous recertification survey of 2/4/16 when this deficiency was cited and she was unaware what their Plan of Correction (POC) included. She stated as of 2/20/17 a new MDS Coordinator was hired to replace the previous MDS Coordinator. She indicated there were issues with the previous MDS Coordinator's evaluation of residents that effected MDS coding and care plans. 2. F279 - Comprehensive Care Plan: Based on record review, resident and staff interview, the facility failed to develop a care plan for the use of antipsychotic and hypnotic medication for two of five residents reviewed for unnecessary medication use (Residents #39 and #44). During the recertification survey of 2/4/16 the facility was cited F279 for failure to develop a care plan for falls. On the current recertification survey of 3/3/17 the facility failed to develop care plans for the use of antipsychotic medication and hypnotic medication. An interview was conducted with the Administrator on 3/3/17 at 11:45 AM. She indicated she had not worked at the facility during the time of previous recertification survey of 2/4/16 when this deficiency was cited and she was unaware what their POC included. She stated as of 2/20/17 a new MDS Coordinator was hired to replace the previous MDS Coordinator. She indicated there were issues with the previous MDS Coordinator's evaluation of residents that effected MDS coding and care plans. 3. F282 - Services Provided as Care Planned:	F 520	notified. A new Incident Log was developed on 3/8/17 and revised on 3/24/17. This new log is designed to validate notification of the physician as well as all other aspects of the policy. It will also serve as an audit tool and will be updated daily by the Administrator or Director of Nursing, Monday through Friday in the morning clinical meeting. The Administrator will bring the results of the Incident Log to the monthly QAPI meetings until 100% compliance is sustained for three months. For F159: A new petty cash system has been implemented to ensure residents have access to their personal funds after business hours and on holidays and weekends. The petty cash system will be managed by the Nursing Supervisor or the licensed nurse on the Tanglewood wing, A new process has been put in place to allow the residents to have access to their personal funds after business hours, on weekends and holidays. Business Office Manager (BOM), personally spoke with resident # 39 on 4/4/17 and explained to him the process to access his funds on the weekends and holidays. He verbalized understanding.	

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F 520	Continued From page 118 Based on observation, staff interview, and record review, the facility failed to follow the care planned interventions for anticoagulant medication (Resident #81), dietary supplements (Resident #117), and restorative nursing services (Resident #42) for 3 of 17 care plans reviewed. During the recertification survey of 2/4/16 the facility was cited F282 for failure to follow the care plan interventions for obtaining a psychiatric consultation and monitoring behaviors for residents on psychotropic medications. During the complaint investigation survey of 9/23/16 the facility was again cited F282 for failure to follow the care plan for wound care. On the current recertification survey of 3/3/17 the facility failed to follow the care planned interventions for anticoagulant medication, dietary supplements, and restorative nursing services. An interview was conducted with the Administrator on 3/3/17 at 11:45 AM. She indicated she had not worked at the facility during the time of previous recertification survey of 2/4/16 when this deficiency was cited and she was unaware what their POC included. She stated their POC from the 9/23/16 complaint investigation included daily Treatment Administration Record (TAR) audits completed by Administrative staff, they hired a new treatment nurse, and implemented a Standards of Care (SOC) Meeting once weekly to review residents based on their needs. She stated this meeting included herself, the Director of Nursing (DON), Social Worker, Treatment Nurse, Dietary Manager, MDS, and Staff Development Coordinator. She additionally stated the floor nurses were responsible for monitoring care plan interventions.	F 520	Residents were notified verbally during the Resident Council Meeting on 4/3/2017 by Activity Director. The Activity Director and/or the BOM will also speak individually with residents having resident fund monies by 4/14/17. Families and Representatives of residents with dementia or cognitive impairment will be notified by letter from the Business Office Manager by 4/14/2017. A record of each transaction will be made by the Nursing Supervisor or Tanglewood nurse at the time of the transaction. The BOM will reconcile the record daily Monday through Friday. Monday the BOM will reconcile transactions made on the week end to ensure the protection of resident funds. Licensed nurses, including weekend and prn nurses, will be in-serviced by the Administrator or the BOM on the new procedure by 4/14/17. The BOM or Administrator, will reconcile cash and withdrawals daily, Monday through Friday, and post such information to each resident's ledger. She will also replace any cash withdrawn from the petty cash box. Any discrepancies or disputes will be promptly reported to the Administrator. One of the department managers will randomly conduct an interview of five (5) residents per week for four (4) consecutive weeks to determine if they were able to access their personal funds after normal business hours or during the weekend or holidays. Random audits of after hour and week end banking will continue monthly for a minimum of three	

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F 520	Continued From page 119 4. F309 - Well-Being: Based on record review, physician interview, and staff interviews, the facility failed to administer a Fentanyl patch (pain medication) for a resident which resulted in increased pain and increased need and request for an as needed Percocet (pain medication) for 1 of 2 residents (Resident #40). During the 2/4/16 recertification survey the failed was cited F309 for failure to provide psychological interventions for residents with behavioral issues. During the complaint investigation survey of 9/23/16 the facility was again cited F309 for the failure to have the resident assessed/examined by a qualified person for possible injuries before moving a resident after the fall and the failure to treat wounds as ordered. On the current recertification survey of 3/3/17 the facility failed to administer a Fentanyl patch to resident. An interview was conducted with the Administrator on 3/3/17 at 11:45 AM. She indicated she had not worked at the facility during the time of previous recertification survey of 2/4/16 when this deficiency was cited and she was unaware what their POC included. She stated the POC from the 9/23/16 complaint investigation included daily TAR audits completed by Administrative staff, they hired a new treatment nurse, and implemented a SOC Meeting once weekly to review residents based on their needs. She indicated they provided education to staff about their policy and procedure related to accidents/incidents. She stated she believed the current citation was unrelated the previous POC. She additionally stated she believed the previous deficiencies had been corrected.	F 520	(3) months. Audit results will be brought to the monthly QAPI Meetings by the BOM. The plan of correction and audit results will be reviewed by the QAPI Committee during monthly meetings. The QAPI Committee will determine continued need for auditing after four (4) months. Completion Date is 4/14/17 For F160: The Business Office Manager refunded a check in the amount of $101.00 to Resident #30's estate on 3/21/2017. Review of the statements for Resident # 38's account, found that no refund is required as a bookkeeping error had recorded the deposit twice. A refund check will be sent to Resident #75 in the amount of $3.00 on 4/6/17 by the Business Office Manager. The Business Office Manager sent a refund check in the amount of $1,028.76 to the estate of Resident #129 on 4/5/17. The Business Office Manager and Administrator completed an audit of discharged residents in the last six months on 3/22/17. Of 64 residents discharged 6 residents were identified to still have funds in their Resident Trust Fund past 30 days. All funds were conveyed to residents on 3/21/2017 by the Business Office Manager.	

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F 520	Continued From page 120 5. F315 - Urinary Catheters: Based on record review, observation, and staff interview, the facility failed to provide catheter care and failed to secure the catheter tubing for 1 (Resident #4) of 1 sampled resident with an indwelling urinary catheter. Resident #4 had three hospitalizations with diagnoses of Urinary Tract Infection (UTI). During the complaint investigation of 11/23/16 the facility was cited F315 for the failure to obtain Urinalysis (UA) with Culture and Sensitivity (C&S) as ordered by the physician and the failure to initiate treatment for a symptomatic UTI. On the current recertification survey of 3/3/17 the facility failed to provide catheter care and failed to secure the catheter tubing. An interview was conducted with the Administrator on 3/3/17 at 11:45 AM. She indicated the POC from the 11/23/16 complaint investigation included a new logging and monitoring system for all laboratory tests ordered by the physician as well as daily follow up with the laboratory. She stated the DON was responsible for this monitoring system. She indicated she was unsure why it was a repeat deficiency. 6. F323 - Accidents: Based on observation, staff and resident interviews, and record review, the facility failed to investigate the root cause of 2 falls and failed to monitor for delayed complications related to a fall for 1 of 2 residents (Resident #42) reviewed for accidents. During the recertification survey of 2/4/16 the facility was cited F323 for failure to properly secure a resident and the wheelchair in the transportation van according, failed to notify the Administrator about the incident, and failed to	F 520	The new Business Office Manager, who started in February 2017, was trained by the facility Administrator and outgoing Business Office Manager on policy and procedures, to include the Resident Trust Fund. Training was conducted from February 9, 2017 to 3/21/17. The facility Administrator will conduct audits of discharged residents who have a Resident Trust Fund weekly for four (4) weeks, then monthly for three (3) months to ensure any trust fund money is conveyed to the resident, responsible party or estate. The plan of correction action(s) will be monitored at the QAPI meeting for a minimum of four (4) months. Audit results will be taken to monthly QAPI meetings by the Business Office Manager. For F166: A grievance form was filled out for resident #72 on 2/2/17 by the Social Worker, Fran Jacobs. The grievance for resident #72 was investigated 2/3/17-2/8/17 by Casey Horne, Director of Nursing. Resolution was determined on 2/8/17 by Casey Horne, DON. Casey Horne, DON, notified the resident of the resolution on 2/8/17 at 2:40pm as validated by Casey Horne, RN, on 3/28/17. A grievance form for Resident # 26 was completed on 2/6/17 by the former Social	

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F 520	Continued From page 121 complete a root cause analysis of the incident. During the 9/23/16 complaint investigation the facility was again cited F323 for failure to raise the lift gate up before pushing a resident who was sitting in a wheelchair out of the transportation van causing the resident to fall backward. On the current recertification survey of 3/3/17 the facility failed to investigate the root cause analysis of falls and failed to monitor for delayed complications related to a fall. An interview was conducted with the Administrator on 3/3/17 at 11:45 AM. She indicated she had not worked at the facility during the time of previous recertification survey of 2/4/16 when this deficiency was cited and she was unaware what their POC included. She reported their POC for the 9/23/16 complaint investigation included discontinuing the use of the facility van for resident transportation. She stated she believed the current citation was unrelated to their previous POC. She additionally stated she believed this was a repeat deficiency because the area of accidents was so broad that a variety of items fell under this categorization. 7. F325 - Nutrition: Based on observation, staff interview, and record review, the facility failed to follow the physician's orders for Remeron (appetite stimulant/antidepressant) and Resource (nutritional supplement) for a resident with significant weight loss (Resident #117) and failed to address weight loss (Resident #87) for 2 of 3 residents reviewed for nutrition. During the recertification survey of 2/4/16 the facility was cited F325 for failure to provide a nutritional supplement as ordered. On the current recertification survey of 3/3/17 the facility failed to	F 520	Worker, Fran Jacobs. It was investigated and corrective action completed on 2/6/17. The Director of Nursing notified resident #26's son on 4/4/17 of the action taken. The son, Todd Maness, confirmed this was addressed and he was previously notified in February 2017. The January grievance log for Resident #72's "Notification of results" section was completed by the Administrator in February 2017. Grievance Policy was revised to reflect: 1) Written grievance decisions include the date the grievance was received, a summary statement of the residents' grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the residents concern(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility because of the grievance, and the date the written decision was issued. 2) The person filing the grievance, resident and/or resident's representative will be informed of the resolution by the Social Services Director or Administrator. 3) A new grievance log was developed and implemented in February 2017. An in-service for all staff, including prn and weekend staff, regarding grievance process will be done by 4/14/2017. The in-services will be presented by the Social Worker and/or Administrator. The Social Services Director and/or	

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F 520	Continued From page 122 follow the physician's orders for an appetite stimulant and nutritional supplement and also failed to address weight loss. An interview was conducted with the Administrator on 3/3/17 at 11:45 AM. She indicated she had not worked at the facility during the time of previous recertification survey of 2/4/16 when this deficiency was cited and she was unaware what their POC included. She stated she believed this was a repeat deficiency because the facility had not firmed up their process for Medication Administration Record (MAR) transcription monitoring. She reported there had been some changes made recently to improve the process. 8. F329 - Unnecessary Medications: Based on record review and staff interview, the facility failed to obtain laboratory values to monitor the use of statin medication for 1 (Resident #39) of 5 sampled residents reviewed for unnecessary drugs. During the recertification survey of 2/4/16 the facility was cited F329 for failure to administer antipsychotic medication as ordered by a physician, failure to monitor behaviors for residents receiving psychotropic medications, and failure to discontinue a medication as ordered. On the current recertification survey of 3/3/17 the facility failed to obtain laboratory values to monitor the use of statin medication. An interview was conducted with the Administrator on 3/3/17 at 11:45 AM. She indicated she had not worked at the facility during the time of previous recertification survey of 2/4/16 when this deficiency was cited and she was unaware what their POC included. She	F 520	Administrator will audit all grievances weekly for four (4) weeks then monthly for 3 months. All grievances will be reviewed for completion of investigation, resolution made and documented and for notification of resolution to the person filing the grievance. The Social Services Director will take audit results to the monthly QAPI meetings for a minimum of four (4) months. After the fourth month, the QAPI Committee will determine if resolution of the problem has occurred or if it needs to continue. For F225: The Nurse Aide Registry cleared NA #2 on 1/25/2017. Re-verification of NA#2 certification, Nurse Aide Registry returned clearance of allegations of alleged abuse. The Staff Development Coordinator conducted an audit on all currently employed Nursing Assistants with the Nurse Aide Registry on 2/25/17 to re-verify none had a finding. There were no negative findings. Resident #36 injury of unknown origin was reported via the 24-hour report to the Health Care Personnel Investigation office by the Administrator on 3/24/17. An investigation was conducted by Director of Nursing and the Administrator and the 5-day report was completed and faxed in on 3/28/17. This was placed on the	

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F 520	Continued From page 123 reported the facility received a monthly report from the pharmacy that included all residents who were on psychotropic medications and anticoagulant medications. She stated this list was utilized for monitoring purposes. She indicated she was unsure why it was a repeat deficiency. 9. F514: Complete and Accurate Clinical Records: Based on record review and pharmacy and staff interview, the facility failed to maintain a complete and accurate medical records as evidenced by medications signed off from the narcotic count were not documented as administered on the resident's Medication Administration Record (MAR) consistently for 3 (Residents #125, #72, and #87) of 5 residents reviewed for complete and accurate clinical records. During the recertification survey of 2/4/16 the facility was cited F514 for failure to maintain complete physician progress notes in the medical records. On the current recertification survey of 3/3/17 the facility failed to maintain complete and accurate medical records as evidenced by medications signed off from the narcotic count were not documented as administered on the resident's MAR consistently. An interview was conducted with the Administrator on 3/3/17 at 11:45 AM. She indicated she had not worked at the facility during the time of previous recertification survey of 2/4/16 when this deficiency was cited and she was unaware what their POC included. She stated she believed multiple changes with staff had contributed to this deficiency. She indicated that ultimately the Unit Managers were	F 520	March Allegation of Abuse log. The facility Administrator and/or the Social Services Director are responsible for reporting allegations of abuse/neglect to HCPR. The facility initiated a new hire process on 3/27/2017. The Administrator will review all applicants background summary and results of the Nurse Aide Registry search prior to orientation. The Human Resources Director will perform all background checks and Nurse Aide Registry searches. The Human Resources Director will complete a check list of all completed paper work for applicants, to include the background check. The HR Director was educated on responsibilities as described by the Administrative Consultant and the facility Administrator on 3/22/17. In-service was done on 3/2/2017 by the Director of Nursing Services and the Administrator with direct care staff, including prn and weekend staff, addressing unusual occurrences that require reporting including appropriate time frame. An Allegation of Abuse Reporting Log has been developed to track timely compliance of allegations of abuse. The log will be maintained by the Administrator and/or the Social Services Director. The Business Office Manager will complete an audit of all applicants	

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F 520	Continued From page 124 responsible for monitoring MARs.	F 520	scheduled for orientation weekly for eight (8) weeks to verify applicant does not have a finding entered in the State Nurse Aide Registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property. The facility Administrator will send the Allegation of Abuse Reporting Log to the Corporate Consultant for the next 5 occurrences to verify appropriate reporting time frames. This will be sent to the Corporate Consultant at the same time the 5 day is sent to the Health Care Personnel Investigation Office. All audits regarding Nurse Aide Registry checks will be taken to the monthly QAPI meetings by the HR Director. Abuse logs will be taken to the monthly QAPI meetings by the Administrator. This plan of correction will be monitored at the monthly QAPI until resolved. For F226: The Nurse Aide Registry cleared NA #2 on 1/25/2017. Re-verification of NA#2 certification. Nurse Aide Registry returned clearance of allegations of alleged abuse. The Staff Development Coordinator conducted an audit on all currently employed Nursing Assistants with the Nurse Aide Registry on 2/25/17 to re-verify none had a finding. There were no negative findings.	

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F 520	Continued From page 125	F 520	Resident #36 injury of unknown origin was reported via the 24-hour report to the Health Care Personnel Investigation office by the Administrator on 3/24/17. An investigation was conducted by Director of Nursing and the Administrator and the 5-day report was completed and faxed in on 3/28/17. This was placed on the March Allegation of Abuse log. The facility Administrator and/or the Social Services Director are responsible for reporting allegations of abuse/neglect to HCPR. The facility initiated a new hire process on 3/27/2017. The Administrator will review all applicants background summary and results of the Nurse Aide Registry search prior to orientation. The Human Resources Director will perform all background checks and Nurse Aide Registry searches. The Human Resources Director will complete a check list of all completed paper work for applicants, to include the background check. The HR Director was educated on responsibilities as described by the Administrative Consultant and the facility Administrator on 3/22/17. An in-service was conducted 3/2/17 by the Director of Nursing Services and the Administrator with all direct care staff, including prn and weekend staff, addressing unusual occurrences that require reporting including appropriate time frame.	

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F 520	Continued From page 126	F 520	An Allegation of Abuse Reporting Log has been developed to track timely compliance of allegations of abuse. The log will be maintained by the Administrator and/or the Social Services Director. The Business Office Manager will complete an audit of all applicants scheduled for orientation weekly for eight (8) weeks to verify applicant does not have a finding entered in the State Nurse Aide Registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property. The facility Administrator will send the Allegation of Abuse Reporting Log to the Corporate Consultant for the next 5 occurrences to verify appropriate reporting time frames. This will be sent to the Corporate Consultant at the same time the 5 day is sent to the Health Care Personnel Investigation Office. All audits regarding Nurse Aide Registry checks will be taken to the monthly QAPI meetings by the HR Director. Abuse logs will be taken to the monthly QAPI meetings by the Administrator. This plan of correction will be monitored at the monthly QAPI until resolved. For F257: Ambient room temperatures are being checked on the 400 hall every morning by the maintenance staff. Resident #7 and	

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F 520	Continued From page 127	F 520	#8 rooms are on the 400 hall. The maintenance director replaced the heat strips in the air handler for 400 hall on March 18th, 2017. Extra blankets were available for residents, including #7 and #8 until the heat strips were received and replaced. Once the heat strips were in place, the 400 hall room temperatures have been in a 71-81-degree range. The Maintenance Director was in-serviced by the Administrator and the Nurse Consultant on 3/6/2017 regarding ambient air temperatures in the facility. Maintenance Director initiated a random daily temperature audit, and a daily morning audit for rooms on the 400 hall. Inside and Outside heating and air units are checked randomly every week while ensuring all units are checked monthly. If the ambient temperature is not within acceptable parameters (71-81 degrees), the thermostats are adjusted accordingly by the Maintenance Department. On 3/9/2017, Wilheim's Heating and Air replaced the compressor and re-wired the condenser. Maintenance Director will continue random Monday through Friday 4 times a day temperature audits thorough 3/31/2017 to ensure comfortable and safe temperatures. 1. How the corrective action(s) will be monitored to ensure the practice will not recur: a. Maintenance Director will continue to conduct random audits of ambient air temperatures weekly times one month and with any significant change in weather	

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F 520	Continued From page 128	F 520	temperature from 4/1/2017- 4/30/2017 for all areas to include rooms 409-412 and 415-418. b. Maintenance Supervisor will conduct monthly inspections of affected units monthly x three (3). Results of Ambient Air Temperature log will be brought to the QAPI committee monthly by the Maintenance Director for review until compliance has been achieved as determined by the Committee. Findings of the April temperature audit will be discussed at the Resident Council in May. For F278: A new MDS Coordinator was hired on 2/20/2017. A new treatment nurse was hired on 1/19/2017. The MDS Coordinator will be in-serviced on assessment accuracy by the Nurse Consultant no later than 4/14/2017. The treatment nurse will be in-serviced on accurately coding Section M by the Nurse Consultant no later by 4/14/2017. A modification assessment was completed on 4/5/2017 by the treatment nurse for Resident #4 to add the dimensions of the identified pressure ulcer. A modified assessment was completed on 4/3/2017 for resident #86 by the MDS Coordinator to code terminal illness in prognosis section. A modification assessment was completed on 4/5/2017 by MDS	

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F 520	Continued From page 129	F 520	Coordinator for resident #81 to correct the coding for hospice. A random audit will be completed on 10% of current residents to assess accuracy of the MDS sections M, item J1400 and O0100 by 4/13/17. Audit will be completed by Nurse Consultants. Moving forward, the treatment nurse will be responsible for completing section M of the MDSs. Prior to closing of any MDS, the MDS Coordinator and at least one Administrative Nurse will review Section M, J1400 and O0100 to ensure accuracy for a minimum of weekly for four weeks, twice a month for one month, then monthly for one month. The deficiency will be placed in the QAPI program for monitoring of resolution/correction. The compliance audits will be reviewed during the monthly QAPI meetings for three (3) months to assure compliance is sustained. The QAPI Committee will determine need to continue or resolve the problem. Audits will be brought to the QAPI Committee by the MDS Coordinator. For F279: Care plans addressing the use of psychotropic medications for residents #39, #44 were developed 3/2/2017 by the MDS Coordinator. A care plan was developed for resident #39 addressing his insomnia and use of hypnotic medications on 3/2/2017 by the MDS Coordinator. The MDS Coordinator will be in-serviced	

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F 520	Continued From page 130	F 520	by the Clinical Nurse Consultant on ensuring care plans are developed as indicated in the CAA and other identified areas of need by 4/13/2017. An audit was completed on 4/2/17 of the 62 residents receiving psychotropic/hypnotic medications to ensure that those residents had a corresponding care plan. 100% of those residents have a care plan in place. The MDS Coordinator has reviewed and updated/created care plans for all residents receiving psychotropic medications on 4/2/2017. Auditing of care plans for resident's receiving psychotropic medications will be completed weekly for 2 weeks, then twice a month for one month, then monthly for four (4)) months by the Director of Nursing, Staff Development Coordinator and/or Nurse Consultant, to ensure a care plan addressing the use of psychotropic medications is in place. The QAPI Committee will review audit results for compliance monthly for six (6) months in the monthly QAPI meeting to assure compliance is sustained. Audit results will be brought to QAPI by the DON. Date of Compliance 4/14/17. For F280: The weight loss care plan for resident #87 was reviewed and revised and updated by facility Registered Dietician 3/23/2017. Care plans of residents with significant weight changes will be audited by Divisional Registered Dietician/ Facility	

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F 520	Continued From page 131	F 520	Dietician to ensure a care plan is present and that appropriate interventions and correct diet are included by 4/14/2017. In-service provided to Food Service Director and facility dietician by Divisional Registered Dietician on developing and updating revision of nutritional care plans on 3/23/2017. Resident #87 will be added to the Standard Of Care (SOC) meeting to be reviewed for weight changes. In-service to ALL dietary staff by Divisional Registered Dietician on 3/22/2017 regarding definition of fortified food, preparation and use of fortified foods. Regional Dietician and Facility Dietician completed a comparison of Meal Tracker diets with those listed for residents to ensure proper diet was being served on 3/23/17. Care plans of residents with significant weight change will be audited weekly for 4 weeks, then 2 times a month for one month, then monthly for 2 months by facility Registered Dietician or Facility Food Service Director (CDM) to ensure a care plan is present with appropriate interventions. The Food Service Director and facility Registered Dietician will be responsible for all nutritional care plans. The facility Registered Dietician/ CDM will update care plans with all significant weight changes. Facility Food Service Director (CDM) will perform a nutritional assessment on all new admissions for nutritional needs during the first week of stay in the facility. The DON or Assistant Director of Nursing	

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F 520	Continued From page 132	F 520	(ADON) will give the CDM a copy of all new diet orders daily Monday-Friday after morning clinical meeting. Weekend orders will be given to the CDM on Mondays. SOC team will review all residents with significant weight changes in SOC meetings weekly until weight is stable or resident has been deemed as "Unavoidable Weight loss" by physician. In-service will be presented to nursing direct care staff by the CDM regarding what fortified foods are and how they can monitor to ensure residents ordered fortified foods are receiving fortified foods at meals by 4/14/2017. The Facility Registered Dietician will be notified of significant weight loss by the CDM as soon as she/he is aware. Audits will be performed by facility Registered Dietician or CDM on residents experiencing significant weight change weekly x 4, then bi- weekly for one month, then monthly for two months Audits will be performed by Facility Registered Dietician or CDM weekly x4, then twice monthly for one month, then monthly for 2 months on care plans correctly reviewed/revised for weight loss. The CDM will do an audit comparing the physician's order to meal tracker tickets weekly for 4 weeks, then twice a month for 1 month, then monthly for two months. The District Manager for Healthcare Services (dietary department) will perform an audit on 4/6/17 comparing meal ticket to meal served . Thereafter, the CDM will perform this audit weekly for four weeks then twice a month for one month, then	

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F 520	Continued From page 133	F 520	monthly for two months. This deficiency will be placed in the QAPI program for monitoring by the QAPI Committee for a period of three (3) months. Audit results will be taken to the QAPI program by the Facility Registered Dietician or CDM. For F281: 1. Immediate action(s) taken for the resident(s) found to have been affected include: a. Resident #1 insulin is being administered as ordered. Blood glucose is being obtained as ordered and sliding scale insulin provided as ordered based on blood glucose. b. Physician and pharmacist will review blood glucose for Resident #1 to ensure current insulin orders and sliding scale coverage is adequate c. Resident #7 is receiving Ativan as ordered. Orders have been reviewed to ensure accuracy and correctness. d. The Medical Administration Record (MAR) for Resident #7 has been reviewed to ensure medication is administered as ordered. e. Resident #117 was discharged but has since been re-admitted to facility on 1/31/2017. f. All new orders will be reviewed in Morning Clinical Meeting. Applicable new orders will be compared to the Medication Administration Record (MAR) by the 11pm to 7am (24 hour chart check) nurse to assure order has been properly transcribed to the MAR.	

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F 520	Continued From page 134	F 520	2. Action taken/system put in place: a. 11pm to 7 am nurses will be inserviced on completing chart checks each evening by 4/7/2017. b. All nurses will be inserviced on the correct procedure in transcribing physician orders by 4/7/2017. c. MARs for the upcoming month will be double checked by administrative nurses against current monthly MARs. 3. How the corrective action(s) will be monitored to ensure the practice will not recur: a. Director of Nursing or designee will audit 10% of new orders to ensure accuracy of new order transcription. Audit weekly for four weeks, bi-weekly for one month, and monthly for one month. b. At the beginning of each month 10% of MARs will be compared to last month MAR for accuracy. Audit weekly for four weeks, bi-weekly for one month, and monthly for one month. The QAPI Committee will review New Order audit for compliance monthly for three (3) months in the monthly QAPI meeting to assure compliance is sustained. Will re-evaluate for compliance for compliance and if compliance is not met will continue for another three (3) months. For F282: Based on review, Resident # 81 is receiving Coumadin as ordered. The Director of Nursing (DON) and Nurse Consultant reviewed the Medication Administration Record (MAR) and current orders on 3/6/17. Resident #117's physician orders were	

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F 520	Continued From page 135	F 520	reviewed by the DON on 3/6/17. Medication and supplements are being administered as ordered. Resident #42 is no longer in facility. All therapy screens for the last 60 days were reviewed on 4/6/17 by the Therapy Director to ensure that residents referred to Restorative program are receiving service. Review revealed all residents referred to the Restorative Program are being seen. All residents on Coumadin are monitored via the Coumadin Audit tracking toll that was initiated December 2016. All resident receiving Coumadin were reviewed for accuracy of their dosage ordered to the MAR by the DON on 3/6/17. The Coumadin Audit Tracking is maintained by the Director of Nurses (DON) and/or the Staff Development Coordinator. Facility Registered Dietician and Divisional Registered Dietician completed a comparison of physician signed orders against Meal Tracker software to ensure 100% accuracy of diets and supplements on 3/23/17. All residents were reviewed to ensure dietary supplements were being given as ordered by the Facility Registered Dietician and the Divisional Registered Dietician. New referrals from therapy will be given to the Director of Nurses (DON). DON will bring referral to Morning Clinical Meeting, referral will be given to MDS Coordinator to be care planned and verified with Restorative that resident is on current	

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F 520	Continued From page 136	F 520	restorative case load. Audit for tracking therapy to restorative referrals will be audited in the Morning Clinical Meeting by the Restorative Nurse. Restorative referrals audit will be done weekly for one month; then twice a /month for one month, then monthly for one month by the Restorative Nurse. Restorative Nurse will also visually validate the Restorative Certified Nursing Assistances are working with the resident being audited. The QAPI Committee will review audit results for compliance monthly for three (3) months in the monthly QAPI meeting to assure compliance is sustained. Will re-evaluate for compliance for and if compliance is not met will continue for another three (3) months. The DON will be responsible for brining the Coumadin Audit log summary to the QAPI Committee. Facility Dietician or the Food Service Director (CDM) will bring audits of dietary supplements being given as ordered to the QAPI meeting. The Restorative Nurse will bring the results to the QAPI meeting for regarding referrals to Restorative being treated. For F285: Resident #81,s level 2 PASRR for SMI was incorporated into his care plan on 3/3/2017 by the MDS Coordinator. Care plan for PASRR level 2 indicating the diagnosis and potential for complications	

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F 520	Continued From page 137	F 520	related to diagnosis were added. On 3/3/2017, the Clinical Nurse Consultant inserviced the MDS Coordinator on incorporating PASRR level 2 information into care plans. The Admission Coordinator conducted an audit on each resident's PASRR level on 3/27/2017. Any residents identified during audit with a PASRR level 2 will have a PASRR level 2 incorporated into the plan of care. There were found to be 15 residents with a PASRR level 2. All of these have been care planned to reviewed and updated to reflect PASRR level 2 presence. The Admission Coordinator will verify new admissions' PASRR screening. When completed ,the Admission Coordinator will notify the MDS Coordinator if resident has a PASRR level 2. The Administrator and/or Social Service Director will audit all new residents and 10% of current residents for accuracy of PASRR level 2 and corresponding care plan monthly for 3 months. The QAPI Committee will review audit results for compliance monthly for three (3) months in the monthly QAPI meeting to assure compliance is sustained. Will re-evaluate for compliance for compliance and if compliance is not met will continue for another three (3) months. Social Service Director will bring audit results to the QAPI Committee Meeting. For F309: Resident #40 is receiving fentanyl patch and prn Percocet.	

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F 520	Continued From page 138	F 520	Pain assessment was completed for resident #40 on 3/23/2017 by her staff nurse. Plan of care was updated on 3/23/2017 by the MDS LPN Coordinator to reflect pain management program, which includes non- pharmacological interventions. Interview with resident #40 has been completed to ensure pain is managed to her satisfaction. Interview was conducted by DON. Resident states she is satisfied with the management of her pain. Education for all nurses on importance of administrating medication as ordered will be completed by Omnicare Pharmacy or Director of Nursing by 4/13/2017. All Nurses will be in-serviced on pain management to include non-pharmacological interventions by Director of Nursing or Staff Development Coordinator by 4/13/ 2017. Pain will be assessed at least each shift and documented on Medication Administration Record (MAR) for all residents by the floor nurse. Identified pain will be addressed appropriately. All residents will have comprehensive pain assessment completed on admission, re-admission, quarterly, and with any significant change as assigned to the floor nurse providing care. All resident who have pain medication scheduled will have a pain management care plan reviewed, updated or initiated by the MDS LPN Coordinator by 4/13/17. An audit of all residents receiving scheduled fentanyl pain patches will be completed by the Medical Records clerk	

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F 520	Continued From page 139	F 520	by 4/13/17 to determine if any other omissions occurred. She will review March 2017 MAR's and April MAR's to date. The Treatment Nurse will conduct an audit monthly for three (3) months, on 25% of the MAR's for residents with scheduled fentanyl patches to determine if omissions have occurred. The QAPI Committee will review monitor for compliance monthly for three (3) months in the monthly QAPI meeting to assure compliance is sustained. Will re-evaluate for compliance for compliance and if compliance is not met will continue for another three (3) months. Treatment nurse will bring the results of the random audit to the QAPI Committee meeting. Compliance date 4/14/17 For F315: Resident #4's urinary catheter was discontinued on 3/15/2017 per physician order. All residents identified with a urinary catheter have a plan of care in place as verified by MDS LPN Coordinator on 3/27/2017. All residents with urinary catheters were observed on 4/5/17, by the treatment nurse to ensure that catheters were in place and secured. The treatment nurse reports that all residents with urinary catheters were in place and secure. One resident refuses drainage bag cover and will move his drainage up above waist while he is up in wheel chair. He refuses	

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F 520	Continued From page 140	F 520	to have it placed lower while he is in wheel chair. All nursing staff will be in-serviced on catheter care, per facility policy, by the Nurse Consultant by 4/13/2017 a. Facility Policy: i. Gather supplies and set up ii. Explain procedure prior to beginning iii. Position resident on back, place protective covering on linens iv. Wash hand and put on gloves v. Wash area front to back, side then other side, then center always turning cloth to clean area before moving to next area. Clean stool prior to starting peri/catheter care. vi. Hold catheter gently but firmly near insertion site. Clean at insertion site then down the catheter with a twisting motion away from the body. vii. Rinse and dry viii. Attach tubing to inner thigh using a fastening devise ix. Place drainage bag in a cover and secure below resident waist. x. Clean area xi. Position resident for comfort xii. Report anything abnormal to nurse for follow up. The Treatment Nurse, on 3/27/17, added Catheter care to the Certified Nursing Assistants documentation on the Activity of Daily Living tracking form for all residents with a urinary catheter. Catheter care was observed by Nurse Consultants from 3/28/17-3/30/17. Floor nurses will be responsible each shift for checking that urinary catheters are in place and secured. They will document	

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F 520	Continued From page 141	F 520	this on the MAR through the month of April Audits will be done by the 11pm-7am Charge Nurse of all residents with a urinary catheter to ensure documentation of catheter care will be done weekly for one month; then random audits will be done monthly for three (3) months to ensure compliance. 11pm-7am Charge Nurse will compile results and provide to Staff Development Coordinator to turn into Staff Development Coordinator weekly. Unit Manager and/or staff nurse will observe Certified Nurse Aides providing urinary catheter care each shift weekly for two weeks then twice a month for one month, then monthly for one month for all residents with indwelling urinary catheters. Observations will be documented and turned in to the Staff Development Coordinator. The QAPI Committee will review audit results for compliance monthly for three (3) months in the monthly QAPI meeting to assure compliance is sustained. Will re-evaluate for compliance for compliance and if compliance is not met will continue for another three (3) months. Staff Development Coordinator will bring results to the QAPI meeting. For F323: Resident #42 is no longer at the facility. Nurses and Certified Nursing Aides were in-serviced by the Director of Nursing (DON), Staff Development Coordinator, and the Nurse Consultant on Prevention and Reporting of Accidents / Incidents on	

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F 520	Continued From page 142	F 520	March 2, 2017. Department heads were educated on 3/22/2017 concerning Root Cause Analysis by the Risk Control Specialist from TIS Health Care Service Division. All Department heads were educated concerning Accident/Incidents on 3/23/2017 by Risk Control Specialist from TIS Health Care Service Division. All nursing staff will be re-educated on Accident/Incident investigations by 4/14/2017 by DON or Staff Development Coordinator. Policy and Procedures related to falls were in-serviced with all staff on 3/14/2017 i. All Accidents/incidents will have an Accident/Incident form completed on the shift it occurred or was noted. ii. Witness statements will be obtained from all involved. iii. Staff is to maintain the safety of the resident. iv. Appropriate preventive interventions will be initiated on recognition of fall risk and after each fall will be updated. v. DON or Staff Development Coordinator will investigate all falls for root cause. Initiation of appropriate intervention will be put in place based on root cause analysis. New referrals from Therapy for Restorative Nursing will be given to the DON. DON will bring referral to the Morning Clinical Meeting, referrals will be given to MDS Coordinator to be cared planned and verified with Restorative Nursing that resident is on current case	

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F 520	Continued From page 143	F 520	load. The Master Incident Log was revised to include environmental assessment on falls. Falls identified as having a possible environmental factor will be evaluated by Maintenance Director or facility Administrator. All residents will have a fall risk assessment completed by the Treatment Nurse. Residents identified as a fall risk will have a fall care plan and measures to prevent falls updated or initiated. This will be completed by 4/13/2017. All falls through March 31, 2017 were reviewed. There were 25 falls in February and 10 falls in March. 6 falls were related to unsteady gait, 15 were related to confusion, 1 equipment issue, 3 behavior related, 1 related to positioning, 8 were related to resident who over estimated their ability to perform a task and 1 related to another resident in a wheelchair. Master Incident Log will be updated in Morning Clinical Meeting Monday through Friday. Weekend incidents will be added to the Master Incident Log on following Monday. Master Incident Log will be completed by Administrator or DON. New referrals from therapy to Restorative Nursing will be given to the DON/ designee. DON will bring referrals to Morning Clinical meeting; referral will be given to the MDS Coordinator to be cared planned and verified with Restorative Nursing to ensure resident is on their case load. Restorative referrals audit will be done weekly for one month, twice a month for one month, then monthly for one month	

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F 520	Continued From page 144	F 520	by the Restorative Nurse. Restorative Nurse will also visually validate the Restorative Certified Nursing Assistants are working with the residents being audited. The QAPI Committee will review audit results from Master Log Form and Restorative Referrals for compliance monthly for three (3) months in the monthly QAPI meeting to assure compliance is sustained. Will re-evaluate for compliance. If compliance is not met review will continue for another three (3) months. The Director of Nursing will be responsible for bringing the Coumadin Audit log summary to the monthly QAPI Meetings. The Food Service Director will bring audits of dietary supplements to the monthly QAPI meetings. The Restorative Nurse will bring the results of the restorative audits to the monthly QAPI Meetings. Date of Compliance 4/14/17 For F325: Resident #117: On 3/22/17, the Regional Registered Dietician reviewed resident's status. She recommended diet liberalization to regular/mech soft with thin liquids to maximize intake, magic cup every day at lunch for nutritional support and to increase protein, house supplement 120ml three times a day and discontinue ensure. Change supplement to provide increased calories and protein for low protein level and aide wound healing, and add vitamin C and zinc for 14 days to promote wound healing. The	

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F 520	Continued From page 145	F 520	physician approved the recommendations. Resident #87: The Regional Registered Dietician reviewed resident's status on 3/23/17. She Recommended discontinuation of protein powder orders secondary to increased protein provide by recommended supplements of house supplement and magic cups. Physician approved recommendations. Weight management plans of care for both Residents #87 and #117 have been reviewed and updated by the MDS LPN Coordinator. Residents will be weighed weekly and discussed in Standard Of Care (SOC) meeting weekly to ensure residents' nutritional needs are being met. Consultant Pharmacist reviewed medications for Resident #117 on 3/28/17 and recommended a Hemoglobin A1C be ordered. The Consultant Pharmacist reviewed medications for resident # 87 on 3/28/17 and recommended reducing dosage of Lexapro. Physician accepted recommendation and order was carried out. Resident #87 and #117, all physician orders were reviewed by the Director of Nursing (DON) on 3/6/17. Medications are being administered as ordered. Facility Registered Dietician and Divisional Registered Dietician will complete a comparison of physician signed orders against MealTracker software to ensure 100% accuracy of diets and supplements by 4/14/17. Residents with significant weight loss noted will be weighed weekly until weight is stable. Residents with significant weight	

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F 520	Continued From page 146	F 520	loss will be discussed in SOC meeting weekly until weight is stable or it determined resident is “Unavoidable Weight Loss”. Food Service Director (CDM) will generate the list of those residents with significant weight loss to be weighed weekly. Staff Nurses may contact the Food Service Director (CDM) to add to this list resident’s they suspect have a weight loss. All new admissions and newly identified residents with weight loss will be communicated with facility Registered Dietician by the Food Service Director (CDM). These residents will also be added to the weekly weight list maintained by the Food Service Director. Restorative Certified Nursing Assistants (RCNA) weigh all residents. They will follow facility policy to weigh all new admissions weekly x4, then monthly unless otherwise indicated by the Restorative Nurse upon review of weights. All residents are weighed monthly. Residents with significant weight changes will be weighed weekly at direction of Restorative Nurse or by agreement of the SOC Committee (members include: DON, Staff Development/Restorative Nurse, MDS LPN Coordinator, Treatment Nurse, Food Service Director, Social Service Director and therapy representative.) All resident’s weights were reviewed for significant changes in weight by the Divisional and Facility Registered Dieticians on 3/23/2017 and 4/7/17. Another audit checking for weight loss will be done on 4/11/17. Care plans were updated by the Divisional and Facility	

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F 520	Continued From page 147	F 520	Registered Dieticians and by the Food Service Directors. Facility Registered Dietician will communicate his/her findings to the Administrator and Director of Nursing. Weights are monitored weekly by the CDM. Residents with significant weight loss will be reviewed in Standards Of Care (SOC) meeting weekly until weight is stable. Food Service Director will bring printed copies of weights to SOC meeting for all members to review. This is an ongoing process to manage significant weight changes in the facility. All new admissions and newly identified residents with weight loss will be communicated with Registered Dietician by the Food Service Director. An audit will be completed by 4/13/17, by a nurse manager, of resident's with orders for Remeron and supplements to ensure they are being given as ordered. Audit will be completed monthly for three (3) months. The QAPI Committee will review audit results for compliance monthly for three (3) months in the monthly QAPI meeting to assure compliance is sustained. Will re-evaluate for compliance for compliance and if compliance is not met will continue for another three (3) months. The Food Service Director will bring significant weight change report to QAPI meeting monthly. For F329: Resident #39: Upon reviewing of medical	

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F 520	Continued From page 148	F 520		

record by the Consultant Pharmacist and the Staff Development Coordinator, lab results were found for a general chemistry profile that included liver function results as well. This was completed 10/4/16, therefore no new liver function panel was ordered. A Lipid panel was drawn 3/24/17 and indicated the following results:

Cholesterol 134 Normal Range 0 -199

Triglycerides 177 (H) 0 -149

HDL-Cholesterol 38.4 (L) 40-60

LDL-Calculated 60 0 -99

VLDL 35 6-40

All residents with cholesterol lowering medications have had a lipid panel performed in the last 12 months or was completed by 4/6/17 as noted by the pharmacist and Staff Development Coordinator. These residents will also have a liver panel performed by 4/13/17 if one has not been completed within the last 12 months.

All residents receiving cholesterol lowering medications will have a lipid panel and a liver panel performed annually. A file has been developed to alert Unit Managers and Director of Nursing (DON) when labs are due for each resident, which includes those with cholesterol lowering medications so that lipid panels are done annually.

Consultant Pharmacist will review medical record of same residents and ensure cholesterol lowering medications

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F 520	Continued From page 149	F 520	have been monitored. Consultant Pharmacist visited on 3/27 & 3/28/17. He reviewed all resident's charts with cholesterol lowering medications, monitoring dosages and labs present or needed. Consultant Pharmacist will review medical record of residents with cholesterol lowering medications to ensure this class of medications have been monitored as evidenced by lab results. This was done on 3/27 & 3/28/17. He will continue this as part of his routine monthly review. All new admission and re-admissions will be reviewed for cholesterol lowering medication monitoring by the DON and/or Assistant Director of Nursing and/or the Staff Development Coordinator. Current residents with new cholesterol lowering medications ordered will be reviewed to ensure lab monitoring is in place. They will be added to the file that alerts Unit Managers and the DON to upcoming labs when orders are reviewed in Morning Meeting by the DON and Unit Manager/ Staff Development Coordinator. The QAPI Committee will review Consultant Pharmacist report brought by the Consultant Pharmacist or DON for compliance monthly for three (3) months in the monthly QAPI meeting to assure compliance is sustained. Will re-evaluate for compliance for compliance and if compliance is not met will continue for another three (3) months. For F333: Resident #81, Coumadin is being administered as ordered. Review was done by the Director of Nursing (DON)	

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F 520	Continued From page 150	F 520	and Nurse Consultant, of the Medication Administration Record (MAR) and current orders on 3/6/17. Resident #81's physician orders have been reviewed to ensure they are current and accurate. Review was done by the Director of Nursing (DON) and Nurse Consultant, of the Medication Administration Record (MAR) and current orders on 3/6/17. Resident #81's MARs have been reviewed to ensure current does is being given as ordered. Review was done by the Director of Nursing (DON) and Nurse Consultant, of the Medication Administration Record (MAR) and current orders on 3/6/17. Resident #87 Ativan is being administered as ordered Review was done by the DON of MAR and current physician's order on 3/6/17. Resident #87's physician orders have been reviewed to ensure current and accurate. Review was done by the DON of MAR and current physician's order on 3/6/17. Resident #87's MARs have been reviewed to ensure current does is being given as ordered. Review was done by the DON of MAR and current physician's order on 3/6/17. Resident #87's is accurate as of March 6, 2017 as reviewed by the DON. All nurses will be educated on importance of documenting narcotic pain medications on MAR as well as maintenance the narcotic count sheet accurately by 4/14/2017. Narcotic Audit sheet for each resident has	

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F 520	Continued From page 151	F 520	been placed in resident's MAR to ensure medications are documented as given. On coming and off going staff nurse will sign that documentation is complete at each change of shift. The Coumadin Audit tracking tool was initiated on December 22, 2016 to monitor Coumadin administration as ordered in response to the medication error cited on December 19, 2016. This tool is maintained by the DON. 11pm to 7am and 7pm -7am nurses will be in-serviced on completing chart checks each evening by 4/14/2017 by the Nurse Consultant or the Corporate Clinical Nurse. All nurses will be in-serviced on the correct procedure in transcribing physician orders by 4/14/2017. MARs for the upcoming month will be double checked by administrative nurses against current monthly MARs. Narcotic Audit sheet for each resident has been placed in resident's MAR will be reviewed daily Monday through Friday by 11p-7a Charge Nurse, Narcotic Audit Sheets for Saturday and Sunday will be included with the audit done on Monday, for one month then weekly for one month, weekly x 2 for one month. Charge nurse will give completed audits with summary to the DON weekly on Fridays. a. The Coumadin Audit tracking tool is monitored by the Director of Nurse daily Monday through Friday. Orders and changes received Saturday and Sunday will be updated to the log on Monday. Any orders initiating and change or new order will be transcribed by the staff nurse	

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F 520	Continued From page 152	F 520	receiving order to include correct transcription to the MAR and lab requested completed as needed. An audit of all residents receiving Coumadin will be completed to verify no medication errors by 4/13/17. The QAPI Committee will review results of the Narcotic Audit and the Coumadin Audit for compliance monthly for three (3) months in the monthly QAPI meeting to assure compliance is sustained. Will re-evaluate for compliance for compliance and if compliance is not met will continue for another three (3) months. Audits will be brought to the QAPI Committee meeting by the DON. For F354: The facility is using the services of a registered nurse for at least eight (8) consecutive hours seven days a week. The Administrator will receive the staffing sheet for the next day with the name of the RN providing RN coverage. The Administrator will then give the sheet to the Human Resource Director (HR). HR will verify that the RN named did provide 8 hours of coverage on the assigned day by checking Time Tender. An audit will be completed daily to reflect the required registered nurse coverage. Audit will be done daily by Human Resources or Administrator by reviewing time tender and comparing with the staff sign in sheet. Nursing schedule is currently managed by the Director of Nursing (DON) with the Staff	

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F 520	Continued From page 153	F 520	Development Coordinator. They review staffing daily for each shift to ensure that there is eight (8) hour coverage by an RN. An audit will be completed daily to reflect the required registered nurse coverage by Human Resources, Administrator and/or Director of Nursing (DON) daily for four weeks, bi-weekly for one month, and monthly for one month. The QAPI Committee will review results of the Registered Nurse Audit for compliance monthly for three (3) months in the monthly QAPI meeting to assure compliance is sustained. Will re-evaluate for compliance for compliance and if compliance is not met will continue for another three (3) months. Audit will be brought to the QAPI Committee by Human Resource Director. For F428: Resident #39: Upon reviewing of medical record by the Consultant Pharmacist and the Staff Development Coordinator, lab results were found for a general chemistry profile that included liver function results as well. This was completed 10/4/16, therefore no new liver function panel was ordered. A Lipid panel was drawn 3/24/17 and indicated the following results: Cholesterol 134 Normal Range 0 -199 Triglycerides 177 (H) 0 -149 HDL-Cholesterol 38.4 (L) 40-60 LDL-Calculated 60 0 -99	

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VLDL 35 6-40

All residents with cholesterol lowering medications have had a lipid panel performed in the last 12 months or was completed by 4/6/17 as noted by the pharmacist and Staff Development Coordinator. These residents will also have a liver panel performed by 4/13/17 if one has not been completed within the last 12 months.
All residents receiving cholesterol lowering medications will have a lipid panel and a liver panel performed annually. A file has been developed to alert Unit Managers and Director of Nursing (DON) when labs are due for each resident, which includes those with cholesterol lowering medications so that lipid and liver panels are done annually.
Consultant Pharmacist will review medical record of same residents and ensure cholesterol lowering medications have been monitored. Consultant Pharmacist visited on 3/27 & 3/28/17. He reviewed all resident's charts with cholesterol lowering medications, monitoring dosages and labs present or needed.
Consultant Pharmacist will review medical record of residents with cholesterol lowering medications to ensure this class of medications have been monitored as evidenced by lab results. This was done on 3/27 & 3/28/17. He will continue this as part of his routine monthly review.
All new admission and re-admissions will be reviewed for cholesterol lowering medication monitoring by the DON and/or

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 155	F 520	Assistant Director of Nursing and/or the Staff Development Coordinator. Current residents with new cholesterol lowering medications ordered will be reviewed to ensure lab monitoring is in place. They will be added to the file that alerts Unit Managers and the DON to upcoming labs when orders are reviewed in Morning Meeting by the DON and Unit Manager/ Staff Development Coordinator. The QAPI Committee will review Consultant Pharmacist report brought by the Consultant Pharmacist or DON for compliance monthly for three (3) months in the monthly QAPI meeting to assure compliance is sustained. Will re-evaluate for compliance for compliance and if compliance is not met will continue for another three (3) months. For F514: Resident #72 physician orders have been reviewed to ensure pain medications ordered are current and accurate. Review was done by the DON of MAR and current physician's order on 3/6/17. Resident #72 MAR and narcotic count sheet have been reviewed to ensure consistency in documentation. Review was done by the DON of MAR and current physician's order on 3/6/17. #125 was discharged on 2/21/17. Closed chart review was done 4/6/17 by Clinical Nurse Consultant. Physician orders, MAR and nurses' notes were reviewed. Resident received medication as ordered. Resident reported medication effective. Resident #125 narcotic count sheets have	

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F 520	Continued From page 156	F 520	been reviewed to ensure consistency in documentation. It was accurate. Resident #72 physician orders for Ativan have been reviewed to ensure ordered are current and accurate Review was done by the DON of MAR and current physician's order on 3/6/17. Resident #72 MAR and narcotic count sheet have been reviewed to ensure consistency in documentation. Review was done by the DON of MAR and current physician's order on 3/6/17. Resident #87's Ativan is being administered as ordered Review was done by the DON of MAR and current physician's order on 3/6/17. Resident #87's physician orders have been reviewed to ensure current and accurate. Review was done by the DON of MAR and current physician's order on 3/6/17. Resident #87's MARs have been reviewed to ensure current does is being given as ordered. Review was done by the DON of MAR and current physician's order on 3/6/17. Resident #87's is accurate as of March 3, 2017 as reviewed by the DON. The Director of Nursing (DON) or Staff Development Coordinator has reviewed all residents' narcotics MAR comparing to resident's narcotic sheet to documentation. Review will be completed by 4/13/17. All nurses will be in-serviced on the importance of documenting narcotic administration in the MAR and maintaining an accurate narcotic count by Pharmacy Nurse Representative, DON,	

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F 520	Continued From page 157	F 520	and Nurse Consultants. In-service will be complete on 4/12/2017. A Narcotic Audit Sheet for each applicable resident will be placed in residents MAR to ensure accuracy of documentation of narcotic medications given as ordered. Director of Nursing or Unit Manager will monitor a minimum of 15 narcotic count sheets and compare with MAR weekly for 4 (4) weeks, twice a month for 1 month, and then one time a month for one month to ensure consistency of documentation. The QAPI Committee will review of MAR Narcotic monitoring for compliance monthly for three (3) months in the monthly QAPI meeting to assure compliance is sustained. Will re-evaluate for compliance for compliance and if compliance is not met will continue for another three (3) months. Audit results will be brought to QAPI Committee meeting by the DON F520 Alliant QIO was contacted by the Administrator on 3/30/17 to request assistance and was told someone would get back with her. On 4/4/17, the Administrator again called asking for assistance. In the afternoon of 4/4/17, Donna Cohen, Task Manager for the QIO, Ms. Cohen, sent the Administrator an email stating she was “connecting us” to Melody Brown, “who heads up the nursing home work” for their organization. The email was copied to Melody Brown. As of 4/13/17, Ms. Brown still had not contacted	

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F 520	Continued From page 158	F 520	us. On 4/17/17, another email was sent to Ms. Cohen stating Ms. Brown had not contacted us and could she herself, assist us. Voicemails were also left on Ms. Cohen's cell phone and office phone on 4/17/17 @ 10:00am. On 4/17/17 at 11:11am, Melody Brown replied by email requesting information on what the facility needs assistance with. Hand in Hand training will be added to our 2017 in-service calendar by second quarter of 2017. The plans of correction for all cited deficiencies, including F tags 279, 282, 309, 315, 323, 325, 329 and 514 will be placed into the QAPI program as action plans. To monitor compliance, all audits will be turned in to the facility Administrator to review for completion and timeliness. All action plans related to the cited tags will remain in QAPI until QAPI Committee determines compliance has been sustained, but at a minimum of six months. The QAPI Committee will include but not be limited to, the Administrator, the Director of Nursing, Staff Development Coordinator/Restorative Nurse, Dietary Manager, the Wound Care Nurse, MDS Coordinator, Business Office Manager, Infection Control Nurse, Maintenance Director and the Medical Director. The QAPI program will involve collecting data, tracking and trending and monitoring of the cited deficiencies and measures/indicators. The QAPI Committee will set goals/benchmarks/thresholds and identify gaps and opportunities. Cited deficiencies and any facility identified	

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F 520	Continued From page 159	F 520	areas of concern that have a direct impact on resident well-being, will be given priority for improvement. Collected data will be used to drive decisions of the Committee. Going forward, the QAPI program will focus on topics that are meaningful and address the needs of residents and staff, e.g. infection control issues, incidents and accidents, pressure injuries, etc. The Committee will charter PIP teams for areas requiring in depth analysis and will practice root cause analysis to get to the root of problems. The QAPI Committee will plan, implement, measure, monitor, and document changes using systematic analysis and systemic action to address identified problems. Moving forward, the QAPI Committee will focus on organizational processes and systems for review and act upon opportunities for improvement as identified above. The Committee will incorporate best practice modalities such as Root Cause Analysis, flowcharts, fishbone diagrams, PDSA and/or other tools as indicated by individual projects. Corporate staff will visit the facility at least 3 days a month. This will include the Administrative Consultant and/or Corporate MDS Nurse. The facility Administrator will send in a weekly report to regional with an update of compliance on each citation.	