STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345179	A. BUILDING: _____ B. WING _____	7/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND RETIREMENT	**752 E CENTER AVENUE MOORESVILLE, NC**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 156	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES

(d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care.

§483.10(g) Information and Communication.
(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility.

(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including:

(i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes -

(A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section;

(B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act.

(C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and

(D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

(ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)
[§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)]

(iii) Information regarding Medicare and Medicaid eligibility and coverage;
[§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)]

(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)

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

The above isolated deficiencies pose no actual harm to the residents

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(B)(iii) of the Older Americans Act); or other No Wrong Door Program;
[§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)]

(v) Contact information for the Medicaid Fraud Control Unit; and
[§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)]

(vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives:

(i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and

(ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.

(g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay.

(i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.

(ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.

(iii) Receipt of such information, and any amendments to it, must be acknowledged in writing;

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(g)(17) The facility must--

(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-

(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;

(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and

(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section.

(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.

(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.

(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.

(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.

(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.

v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview the facility failed to provide the Notice of Medicare Non-Coverage (NOMNC) a minimum of 2 days prior to the end date of Medicare services for 1 of 3 residents (Resident #13) reviewed for liability notices.

Findings included:

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Resident #13 was readmitted to the facility on 11/30/16.

An interview was conducted with the Business Office Manager (BOM) on 07/14/17 at 2:54 PM who stated she was responsible for providing the NOMNC a minimum of 2 days prior to the skilled service end date. The BOM confirmed Resident #13's skilled services began on 11/30/16 and ended on 01/23/17. She was unable to provide documentation Resident #13 had been given a NOMNC form prior to her discharge from skilled services on 01/23/17. The BOM explained she had just started employment and must have missed providing Resident #13 with the NOMNC.

An interview was conducted with the Administrator on 07/14/17 at 4:49 PM. She stated it was her expectation the NOMNC would be provided within the required time frame.

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F 157 SS=G	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. (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	F 157		8/19/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/08/2017

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F 157	Continued From page 1 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 reviews, staff interviews, nurse practitioner and Medical Doctor (MD) interviews, the facility failed to notify the nurse practitioner and the physician of development of pressure ulcer in 1 of 4 sampled residents. (Resident #69). The findings included: Resident #69 readmitted on 06/15/17 to the facility with diagnosis that included: recent aspiration pneumonia, previous stroke with residual hemiplegia, peripheral vascular disease. The Minimum Data Set assessment dated 06/22/17 for the quarterly assessment indicated that resident was severely impaired cognitively. The resident also required extensive assistance for bed mobility/positioning and transfers from bed. He was dependent for all personal care. The resident received nutrition through a feeding tube and was dependent on supplemental oxygen. Review of skin assessment form dated 06/15/17 revealed Resident #69 had an reddened area on left heel. Review of physician order summary dated	F 157	1. MD notified of resident #69□s pressure ulcer on 6/25/17. New order received for treatment to pressure ulcer and treatment initiated. Wound Treatment Nurse Practitioner assessed resident #69 on 6/27/17 and new treatment orders were initiated at that time. 2. All residents with pressure ulcers have the potential to be affected by the alleged deficient practice. Administrative RN (DON,ADON,Nurse Manage, Unit Coordinator)completed an audit of all residents with pressure ulcers to ensure treatment orders were in place and Practitioner notification occurred. Audit completed 8/4/17. MD made aware of any areas of change if necessary. 3. Licensed nursing staff will be re-educated by DON/ADON by 8/19/17. Education to include skin management, treatment initiation, and Practitioner notification of new and/or change in pressure ulcers. Administrative RN (DON,ADON,Nurse Manage, Unit Coordinator)will review new admission skin assessments in IDT meeting the following day of admission or on Monday after weekend admissions to	

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F 157	Continued From page 2 06/15/17 for readmission to the facility did not include orders for pressure area on left heel. Review of MD orders for Resident #69 revealed no orders for left heel pressure ulcer until after nurse assessment dated 06/25/17. Review of treatment administration record for June 2017 revealed wound care initiated for left heel unstageable pressure ulcer on 06/25/17 by Wound Treatment Nurse Practitioner. Interview conducted with Nurse # 3 on 07/13/17/ at 11:25 AM. Nurse #3 stated that the reddened area on the left heel of Resident #69 was not reported to the Nurse Practitioner or the MD after the skin assessment dated 06/15/17. Interview conducted on 07/14/17 at 10:04 AM with Nurse Practitioner (NP). NP stated that she was not aware that Resident #69 had a pressure ulcer on his left heel. The NP stated it was her expectation to be notified of new wounds or other changes in the condition of residents. An interview was conducted on 07/14/17 at 5: 53 PM with MD. MD stated it was her expectation to be notified if residents developed new wounds.	F 157	ensure any areas noted have active treatment orders and practitioner notification occurred. IDT will review new admission skin assessments on going. 4. Administrative RN (DON,ADON, Nurse Manager, Unit Coordinator) or designee will review all identified pressure areas to ensure treatment in place, practitioner notification occurred and any changes to pressure area 4x a week for 4 weeks, then 2x a week for 2 weeks, then 1 time a week for 1 month. Data obtained during the audit process will be analyzed for patterns and trend and reported to Quality Assurance (QAPI) for 3 months, at which time the QAPI committee will evaluate the effectiveness of the interventions and make recommendations to determine if further auditing is needed to sustain compliance on going.	
F 166 SS=B	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	F 166		8/19/17

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F 166	Continued From page 3 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 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;	F 166		

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F 166	Continued From page 4 (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; (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.	F 166		

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F 166	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to ensure the grievance investigations and resolutions were provided in writing to 3 of 3 sampled residents and/or their responsible parties (Residents #93, #29 and #147). Findings included: 1. Resident #93 was admitted to the facility on 06/07/17 with diagnoses which included congestive heart failure, muscle weakness, diabetes and chronic obstructive lung disease. A review of the admission Minimum Data Set (MDS) dated 06/15/17 revealed Resident #93 had short term and long term memory problems and was severely impaired in cognition for daily decision making. The MDS further revealed Resident #93 required limited assistance with locomotion but required extensive assistance with all other activities of daily living (ADL). A review of a facility document titled Concern Form dated 06/19/17 indicated Resident #93's name at the top of the form and the form was signed by Nurse #1. A section labeled Description of Concern included in part: hallway smelled of urine and feces, an employee was texting on her phone and walking slowly down the hallway to resident's room, resident was covered in feces and was not wearing a brief, family noticed a bed sore on resident's buttocks, resident did not have an alarm pad in bed; had feces under his nails and nails were at least 2 inches long, bathroom was very dirty with used gloves, gauze and razor in the sink, toilet was covered with urine and a trail of feces was on the	F 166	1. Resident # 93, Resident # 29, and Resident # 147 are no longer residing in facility. 2. All concerns in the last 30 days related to current residents will be reviewed and written resolutions will be presented to each person voicing said concern. 3. Education will be provided to all department managers by the Administrator regarding resolution of concerns and follow-up expectations, inclusive of written resolutions being provided. 4. Five grievances per week will be reviewed by the Administrator or designee 5 x weekly to ensure written resolutions have been provided by the department head as assigned by the Administrator. Results will be brought to QAPI x 3 months, or until no further issues noted.	

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floor in the hallway. A section labeled Action taken revealed a Customer Service in-service was conducted with staff, re-education was conducted with staff regarding ADL care, the spots on the hallway floor were determined to be marks on the floor and not from a bowel movement and Resident #93 had no open areas on his buttocks. The document revealed a meeting was held on 06/20/17 with the responsible party but there was no indication a written decision of resolutions had been sent to the responsible party.

During an interview on 07/12/17 at 6:18 PM the Social Worker confirmed she was not responsible for grievances in the facility but the Administrator was in charge of handling them.

During an interview on 07/12/17 at 6:31 PM, Nurse #1 stated she was also a Unit Manager and provided supervision to staff. She confirmed she was working when family had complained to her about Resident #93's care. She stated she had documented the concerns on the Concern Form and then gave it to the Director of Nursing (DON).

The DON was unavailable for interview on 07/14/17 at 10:00 AM.

During an interview on 07/14/17 at 2:37 PM, the Administrator stated she had only worked in the facility for 2 weeks and was still trying to figure out processes in the facility. She stated she was aware of the new regulations related to grievances and it was her expectation that anybody could complete a concern form but they should let her know so she could log it. She explained she expected for follow up to be done

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with the individual who filed the complaint or grievance. She further stated she had raised questions about sending follow up letters regarding grievance decisions but had been told not to send follow up letters unless they were requested. She confirmed the grievance policy was updated in May 2017 and no follow up letters with resolutions to concerns or grievances had been sent to residents or their responsible parties.

2. Resident #29 was re-admitted to the facility on 02/10/17 with diagnoses which included heart failure, high blood pressure, diabetes, dementia and depression. A review of the quarterly Minimum Data Set (MDS) revealed Resident #29 was severely impaired in cognition for daily decision making. The MDS further revealed Resident #29 required extensive assistance with toileting and hygiene.

A review of a facility document titled Concern Form dated 06/16/17 indicated Resident #29's name at the top of the form and the form indicated a family member had expressed concerns. A section labeled Description of Concern included in part that family was not informed of a fall last night, a nurse noted Resident 29's brief was wet and 2 hours later family went to the nursing station and was told by a nurse to turn on the call light and Resident #29 was not sent to dialysis. A section labeled action taken indicated in part the responsible party was contacted regarding the fall, staff in-services were conducted regarding incontinence care and Resident #29 was not medically stable some days and did not go to dialysis. The document revealed a meeting was held with the responsible party on 06/16/17 but there was no indication a written

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decision of resolutions had been sent to the family member or the responsible party.

The Director of Nursing was unavailable for interview on 07/14/17 at 10:00 AM.

During an interview on 07/14/17 at 2:37 PM, the Administrator stated she had only worked in the facility for 2 weeks and was still trying to figure out processes in the facility. She explained she expected for follow up to be done with the individual who filed the complaint or grievance. She stated the former Administrator had reviewed the concerns expressed by Resident #29's family but she confirmed no follow up letter with resolutions to their concerns had been sent to Resident #29's family.

3. Resident #147 was re-admitted to the facility on 06/15/17 with diagnoses which included high blood pressure, diabetes, seizures and depression. A review of the admission Minimum Data Set (MDS) dated 06/26/17 revealed Resident #147 was moderately impaired in cognition for daily decision making and required limited assistance with eating.

A review of a facility document titled Concern Form dated 06/19/17 indicated Resident #147's name at the top of the form and the form indicated Resident #147 had filed a concern. A section labeled Description of Concern included in part that Resident #147 had received artificial sweetener on his tray and he could not have it because he was allergic to it. The document revealed in a section labeled action taken the Dietary Manager in-serviced dietary staff and she would monitor for compliance. The document further revealed there was no indication a written

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F 166	Continued From page 9 decision of resolutions had been sent to Resident #147. The Director of Nursing was unavailable for interview on 07/14/17 at 10:00 AM. During an interview on 07/14/17 at 2:37 PM the Administrator stated she had only worked in the facility for 2 weeks and was still trying to figure out processes in the facility. She explained she expected for follow up to be done with the individual who filed the complaint or grievance. She stated she was aware of the concern expressed by Resident #147 but confirmed no follow up letter with resolutions to Resident #147's concerns had been sent to him.	F 166		
F 224 SS=G	483.12(b)(1)-(3) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(b) The facility must develop and implement written policies and procedures that: (b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (b)(2) Establish policies and procedures to investigate any such allegations, and (b)(3) Include training as required at paragraph	F 224		8/19/17

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F 224	Continued From page 10 §483.95, This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, staff and family interviews the facility neglected to assess and provide treatment for pressure ulcer and neglected to clean and trim a dependent residents finger nails for 1 of 3 residents. (Resident # 69). The facility neglected to assess and seek treatment for Resident #69 which resulted in a decline of the pressure ulcer condition from redness upon admission on 06/15/17 to black necrotic tissues on 06/25/17. The findings Included: 1. Resident #69 readmitted to the facility with diagnosis that included: recent aspiration pneumonia, previous stroke with residual hemiplegia, and peripheral vascular disease. The Minimum Data Set quarterly assessment dated 06/22/17 indicated that resident #69 was severely impaired cognitively. The resident also required extensive assistance for bed mobility/positioning and transfers from bed. He was dependent on staff for all personal care. The resident received nutrition through a feeding tube and was dependent on supplemental oxygen. Review of skin assessment form dated 06/15/17 revealed resident had an area of reddened skin on right heel. The form was not completed in the area intended for documentation of size, type, and description of the wound. Review of medical record revealed follow up weekly skin assessment was dated 06/25/17. Review of MD orders for Resident #69 revealed	F 224	1. Resident #69□s nails were trimmed by NA on 7/14/17. Pressure ulcer treatment initiated for resident #69 on 6/25/17. 2. All residents with pressure areas have the potential to be affected by the alleged deficient practice. Administrative RN (DON,ADON,Nurse Manager, Unit Coordinator) completed an audit of all residents with pressure areas on 8/4/17 to ensure treatment initiated and Practitioner notification occurred. No areas of concern noted. All dependent residents (residents with an ADL score of 10 or greater) have the potential to be affected by the alleged deficient practice. Administrative RN (DON,ADON,Nurse Manager, Unit Coordinator) completed an audit of all dependent resident□s finger nails to ensure nails were trimmed and clean on 7/14/17. No areas of concern noted. 3. Nursing staff will be educated by DON/ADON by 8/19/17 regarding initiating treatment for pressure ulcers and practitioner notification of pressure ulcer; including noting changes in ulcer. Any staff that have not completed the education will not work until education is completed. Certified Nursing assistants will be re-educated by DON/ADON by 8/19/17 regarding ADL care to include trimming and cleanliness of resident finger nails. All nursing staff will be re-educated regarding resident neglect in relation to ADL care	

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F 224	Continued From page 11 wound care orders which were initiated on 06/25/17 for an unstageable pressure ulcer on the left heel. An observation was made of the wound on the left heel of Resident #69 on 07/12/17 at 2:17 PM. The wound on the resident's left heel had pink and greyish tissue and the wound was surrounded by darkened flaky skin. An interview was conducted with Nurse #2 who stated that she had completed the skin assessment of Resident #69 on date of readmission 06/15/17. Nurse #2 stated that she had marked the form incorrectly. Nurse # 2 stated that the reddened area had been on the left heel of Resident #69. Nurse #2 also stated that she had not documented the description or size of the area on the left heel. An interview was conducted with Wound Care Specialist on 07/14/17 at 11:07 AM. The Wound Care Specialist stated that the resident had a Stage III pressure ulcer on his left heel. The Wound Care Specialist stated also that it was her expectation that wounds would be assessed and documented in the medical record. The Assistant Director of Nursing (ADON) was interviewed on 07/13/17 at 3:51 PM. The ADON stated it was her expectation that a skin assessment would be filled out completely to include description of and measurement of wounds for residents with wounds. The ADON stated it was also her expectation that wounds had follow up assessment completed weekly or whenever the condition of the wound changed. An interview was conducted with the facility	F 224	and treatment of pressure ulcers.. 4. Administrative RN (DON,ADON,Nurse Manage,Unit Coordinator) or designee will audit all residents with pressure ulcers for changes, notification and active treatment 4 times a week for 4 weeks, then 2 times a week for 2 weeks, and then 1 time a week for 1 month. Administrative staff or designee will audit dependent residents (residents with an ADL score of 10 or greater) to ensure lengthy fingernails are trimmed and nails are clean 3 times a week for 4 weeks then 2 times a week for 2 weeks and then weekly for 3 months. Data obtained during the audit process will be analyzed for patterns and trends and reported to the QAPI committee by the Adminstrative RN (DON,ADON,Unit Manager,Unit Coordinator) or designee for 3 months at which time the committee will evaluate the effectiveness of the interventions and determine if further auditing is needed.	

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F 224	Continued From page 12 Medial Doctor (MD) on 07/14/17 at 5:53 PM. The MD stated that it was the expectation that wounds be assessed and MD be notified of wounds. 2. Resident #69 was readmitted to the facility on 05/04/17 with diagnoses that included: cerebrovascular accident with hemiplegia, seizure disorder, contracture of right wrist and elbow, and others. Review of the most recent quarterly minimum data set (MDS) dated 06/22/17 revealed that Resident #69 was severely cognitively impaired for daily decision making. The MDS also revealed that Resident #69 required total assistance of 1 staff member for personal hygiene. An interview and observation was conducted on 07/11/17 at 2:51 PM with Nursing Assistant (NA) #1. NA #1 stated she routinely cared for Resident #69 on first shift. She stated that she had bathed Resident #69 this am and she had not noticed that his nails needed to be trimmed but after looking at them confirmed that they "definitely need to be trimmed and cleaned." NA #1 added that she checked fingernails every other day and had just not noticed Resident #69's but she would take care of them right away. An observation of Resident #69 was made on 07/11/17 at 3:43 PM. All of Resident #69's fingernails were noted to be a quarter inch long and had dried brown substance under them.	F 224		

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F 224	Continued From page 13 An observation of Resident #69 was made on 07/12/17 at 9:38 AM. All of Resident #69's fingernails were noted to be a quarter inch long and had dried brown substance under them. A follow up interview was conducted with NA #1 on 07/13/17 at 10:24 PM. NA #1 stated she had not had the time to go back to clip or clean Resident #69's fingernails. NA #1 added she would take care of it right away. An observation of Resident #69 was made on 07/14/17 at 9:52 AM. All of Resident #69's fingernails were noted to be a quarter inch long and had dried brown substance under them. The Assistant Director of Nursing (ADON) was unavailable for interview on 07/14/17 at 10:00 AM. The Director of Nursing (DON) was unavailable for interview on 07/14/17 at 10:00 AM. An interview was conducted with the Administrator on 07/14/17 at 10:32 AM. The Administrator stated that she expected the staff to cut, clean, and trim residents fingernails and toenails as needed. An interview was conducted with the District Director of Clinical Services (DDCS) on 07/14/17 at 4:04 PM. The DDCS stated the staff was expected to check fingernails on a daily basis and trim and clean them as needed.	F 224		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		8/19/17

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F 226	Continued From page 14 483.12 (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, (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 reviews and staff interviews the facility failed to follow their Abuse and Neglect Prohibition policy in the area of training when they failed to train 3 of 3 agency staff on their Abuse and Neglect Prohibition policy (Nursing Assistant	F 226	1. Agency Staff NA #3, and #7 were re-educated regarding the Abuse Prohibition. NA #2 has not returned to facility. 2. Current agency staff contracted to the	

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F 226	Continued From page 15 #2, #3, and #7). The findings included: Review of a facility policy titled Abuse and Neglect Prohibition revised January 2017 read in part, Training: "The facility will train each employee on this policy during orientation, annually, and more often as determined by the facility. The facility will provide training regarding related policies and procedures. The facility will provide education for those additional individuals involved with the resident. The facility indicated that there was not a separate policy for agency or contract staff. A. An interview was conducted with Nursing Assistant (NA) #2 on 07/12/17 at 6:19 PM. NA #2 stated she worked for a local staffing agency and had been working at the facility for 3 weeks. NA #2 stated that she had not have any training on abuse or neglect when she came to the facility and "she did not need any training." She added that she if witnessed abuse she would report it to the scheduler at the facility. Review of document titled "Agency Personnel/Contractors Checklist" (a check list that listed all the policies the agency staff was to be educated on) for NA #2 revealed that abuse prohibition was checked off indicating the policy had been reviewed with NA #2. The form was not dated or signed by the facility or NA #2. The Assistant Director of Nursing (ADON) was unavailable for interview on 07/14/17 at 10:00 AM. The Director of Nursing (DON) was unavailable for interview on 07/14/17 at 10:00 AM.	F 226	facility were re-educated regarding abuse policy and reporting abuse. Education to be provided by the Social Services Director or designee to include types of abuse and reporting to the Abuse Officer, DON, or Nurse Supervisor. 3. Any new agency staff scheduled to work in the facility after 7/14/17 shall not work prior to receiving education on Abuse and neglect. 4. Weekly monitoring of signed Abuse/Neglect education material from all agency staff members assigned to facility times four weeks. All signed education material from agency staff will be reviewed weekly by the QAPI Committee for 3 months at which time the committee will evaluate the effectiveness of the audit and determine if further auditing is needed.	

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An interview was conducted with the Administrator on 07/14/17 at 10:26 AM. The Administrator stated she had only been at the facility for 2 weeks and was unsure who handled the training of new employees. She added that she did expect that all staff including agency staff to be trained on abuse and neglect prior to providing any care to the residents.

An interview was conducted with the District Director of Clinical Services (DDCS) on 07/14/17 at 4:02 PM. The DDCS stated she expected that all staff including agency staff to be trained on the facility's abuse and neglect policy before they started caring for the residents. The DDCS explained that the facility staff was responsible for providing the required education even if was a brief verbal exchange of the required policies and procedures.

B. An interview was conducted with Nursing Assistant (NA) #3 on 07/14/17 at 10:11 AM. NA #3 stated that she worked for a local staffing agency and had been coming to the facility off and on for about 2 weeks. NA #3 stated that she had not received any training from the facility when she started working here.

The facility was unable to produce the "Agency Personnel/Contractors Checklist" for NA #3.

The Assistant Director of Nursing (ADON) was unavailable for interview on 07/14/17 at 10:00 AM.

The Director of Nursing (DON) was unavailable for interview on 07/14/17 at 10:00 AM.

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An interview was conducted with the Administrator on 07/14/17 at 10:26 AM. The Administrator stated she had only been at the facility for 2 weeks and was unsure who handled the training of new employees. She added that she did expect that all staff including agency staff to be trained on abuse and neglect prior to providing any care to the residents.

An interview was conducted with District Director of Clinical Services (DDCS) on 07/14/17 at 4:02 PM. The DDCS stated she expected that all staff including agency staff to be trained on the facility's abuse and neglect policy before they started caring for the residents. The DDCS explained that the facility staff was responsible for providing the required education even if was a brief verbal exchange of the required policies and procedures.

C. An interview was conducted with Nursing Assistant (NA) #7 on 07/14/17 at 6:23 AM. NA #7 stated he worked for a local staffing agency and had been working at the facility since March 2017. NA #7 stated he had not received any training from the facility staff in orientation or since he had worked there.

The facility was unable to produce the "Agency Personnel/Contractors Checklist" for NA #7.

The Assistant Director of Nursing (ADON) was unavailable for interview on 07/14/17 at 10:00 AM.

The Director of Nursing (DON) was unavailable for interview on 07/14/17 at 10:00 AM.

An interview was conducted with the Administrator on 07/14/17 at 10:26 AM. The

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F 226	Continued From page 18 Administrator stated she had only been at the facility for 2 weeks and was unsure who handled the training of new employees. She added that she expected all staff including agency staff to be trained on abuse and neglect prior to providing any care to the residents. An interview was conducted with the District Director of Clinical Services (DDCS) on 07/14/17 at 4:02 PM. The DDCS stated she expected all staff including agency staff to be trained on the facility's abuse and neglect policy before they started caring for the residents. The DDCS explained the facility staff was restaff was responsible for providing the required education even if was a brief verbal exchange of the required policies and procedures.	F 226		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, family, and significant other interviews the facility failed to dress dependent residents in a dignified manner for 2 of 3 residents sampled for dignity (Resident #69 and Resident #99). The findings included: 1. Resident #69 was admitted to the facility on 01/28/16 and was readmitted to the facility on	F 241	1. Personal Preferences and Kardex updated for Resident #69. NA #1 and NA #5 were re-educated on adhering to resident's Kardex (care plan goals and personal preference) including clothing resident to promote dignity and respect on 7/17/17. 2. Current residents have the potential to be affected by the alleged deficient practice. All current residents' personal	8/19/17

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F 241	Continued From page 19 05/04/17 with diagnoses that included: history of cerebrovascular accident with hemiplegia, seizure disorder, contracture of right wrist and elbow, and others. Review of the most recent quarterly minimum data set (MDS) dated 06/22/17 revealed that Resident #69 was severely cognitively impaired for daily decision making and had no speech. The MDS also revealed that Resident #69 required total assistance of 1 staff member for dressing and no rejection of care was noted during the assessment period. An observation of Resident #69 was made on 07/09/17 at 12:26 PM. Resident #69 was resting in bed and was dressed in a hospital gown. An observation of Resident #69 was made on 07/10/17 at 12:30 PM. Resident #69 was resting in bed and was dressed in a hospital gown. An interview was conducted with Nursing Assistant (NA) #1 on 07/11/17 at 2:51 PM. NA #1 stated that she routinely cared for Resident #69 on first shift. She stated that she gave him a bed bath and placed a fresh gown on him daily. NA #1 stated that she left him in a gown "so he can rest better since he did not get out of bed." An observation of Resident #69 was made on 07/11/17 at 3:43 PM. Resident #69 was resting in bed and was dressed in a hospital gown. An interview with Resident #69's family was conducted on 07/12/17 at 9:31 AM. The family member stated that he visited Resident #69 several times a week and when he visited Resident #69 was always in the bed and in a	F 241	preference interviews completed 8/9/17 and Kardex updated to reflect residents' choices. 3. NA #1 and NA #5 were re-educated on adhering to resident's Kardex (care plan goals and personal preference) including clothing resident to promote dignity and respect on 7/17/17. Staff (licensed and unlicensed) will be re-educated on dignity and respect; to include dressing residents in a dignified manner as well as clothing of residents' choice (personal preference) by DON and/or designee. 4. Resident Ambassadors (department heads) and/or Licensed Nursing Staff will monitor residents to ensure residents personal clothing choice is honored utilizing residents individual Kardex (care plan goals and personal preferences). Resident Ambassadors will audit 10 residents 4 times a week for 4 weeks, then 2 times a week for 2 weeks, and then 1 time a week for 4 weeks. Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance (QAPI), at which time the committee will evaluate the effectiveness of the interventions and determine if further auditing is needed to sustain compliance.	

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hospital gown. The family member stated that the facility was supposed to dress him every day and he had plenty of clothes in his closet and there was no excuse why he was not dressed. The family stated that Resident #69 was up every day and dressed prior to coming to the facility and he would certainly want to be dressed each day.

An interview with Resident #69's significant other was conducted on 07/13/17 at 8:54 AM. She stated she visited with Resident #69 several times a week and when she visited Resident #69 was always in a hospital gown. The significant other stated that Resident #69 was a truck driver and he was up and dressed every single day and he would not want to stay in a hospital gown and in the bed all the time.

The Assistant Director of Nursing (ADON) was unavailable for interview on 07/14/17 at 10:00 AM.

The Director of Nursing (DON) was unavailable for interview on 07/14/17 at 10:00 AM.

An interview was conducted with the Administrator on 07/14/17 at 10:32 AM. The Administrator stated that she expected the staff to dress each resident in a dignified manner and not be left in a hospital gown all the time.

An interview was conducted with the District Director of Clinical Services (DDCS) on 07/14/17 at 4:04 PM. The DDCS stated the staff was expected dress each resident in a dignified manner. She added if the dignified manner was to be dressed in regular clothes then the resident should be dressed in regular clothes and not left in a hospital gown.

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2. Resident #99 was admitted to the facility on 07/19/16 with history of persistent vegetative state (unresponsive to physical or psychological stimuli), tracheostomy, dysphagia (difficulty swallowing), cerebrovascular disease, aphasia (unable to speak) and seizures.

Review of the most recent significant change Minimum Data Set (MDS) dated 05/16/17 revealed Resident #99 to be severely impaired in cognition for daily decision making. The MDS further revealed Resident #99 was totally dependent for dressing with 2 person physical assist.

Observation on 07/10/17 at 11:14 AM revealed Resident #99 was in bed, dressed in a hospital gown.

Observation on 07/11/17 at 11:12 AM revealed Resident #99 was in bed, dressed in a hospital gown. The hospital gown was observed to be loose fitting to the point where Resident #99's shoulder and upper chest were exposed.

Observation on 07/11/17 at 3:44 PM revealed Resident #99 was in bed, dressed in a hospital gown.

Observation on 07/12/17 at 9:55 AM revealed Resident #99 was in bed, dressed in a hospital gown.

An interview was conducted on 07/12/17 at 4:49 PM with a family member of Resident #99. She

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stated she would like to see Resident #99 dressed "at least a couple of times per week." She stated the facility told her previously "it was easier" to have Resident #99 dressed in a hospital gown. She further stated if Resident #99 could speak for himself, he would want to be dressed every day because before his current condition, Resident #99 was "a sharp dressed man". She also stated she had noticed several times when she had entered the room that his gown was not secured and was sliding down, leaving Resident #99 exposed and seeing him like that bothered her.

Observation on 07/12/17 at 5:27 PM revealed Resident #99 was in bed, dressed in a hospital gown.

An interview with NA #5 on 07/14/17 at 10:15 AM revealed there was no specific reason Resident #99 was dressed in a hospital gown and she believed Resident #99's family might have requested he was dressed in a gown. She stated it made providing care for Resident easier #99 due to his catheter.

The Assistant Director of Nursing (ADON) was unavailable for an interview on 07/14/17 at 10:27 AM.

The Director of Nursing was unavailable for an interview on 07/14/17 at 10:27 AM.

An interview was conducted with the Administrator on 07/14/17 at 10:32 AM. The Administrator stated she expected the staff to dress each resident in a dignified manner and they should not be left in a hospital gown all the time.

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F 241	Continued From page 23 An interview was conducted with the District Director of Clinical Services (DDCS) on 07/14/17 at 4:04 PM. The DDCS stated that the staff was expected to dress each resident in a dignified manner. She added that if the dignified manner was to be dressed in regular clothes then the resident should be dressed in regular clothes and not left in a hospital gown.	F 241		
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews the facility failed to honor a resident's choice to have a shower every day for 1 of 4 residents sampled for choices (Resident #91). The findings included: Review of a facility document titled "Resident Preference Evaluation" dated 08/04/16 indicated	F 242	1. Resident #91's personal preference interview assessment was updated on 7/19/17 to reflect the resident's current shower preference. Kardex for resident #91 was updated at this time. 2. Current residents have the potential to be affected by the alleged deficient practice. Administrative Staff(Department Heads) completed/updated all current	8/19/17

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F 242	Continued From page 24 that Resident #91 requested a shower daily in the afternoon or evening. This was signed by the Director of Activities (DOA). Resident #91 admitted to the facility on 03/07/14 and readmitted on 12/07/14 with diagnoses that included weakness, major depressive disorder, and anxiety. Review of the most recent quarterly minimum data set (MDS) dated 05/08/17 indicated that Resident #91 was cognitively intact and required limited assistance of 1 staff member for bathing. No rejection of care was noted during the assessment period. An interview was conducted with Resident #91 on 07/10/17 at 2:02 PM. Resident #91 stated she received 2 showers a week but was used to taking a shower every day prior to coming to the facility. She added that she used to take a shower every day and the staff would supervise but now I receive my showers 2 times a week. Review of the Shower Book located at the nurse's station on 07/12/17 at 10:50 AM revealed that Resident #91's shower days were Monday and Thursday. Review of Resident #91's kardex on 07/12/17 at 10:55 AM revealed that the staff was to supervise Resident #91 in the shower. The kardex said nothing about daily showers. An interview was conducted with Nursing Assistant (NA) #5 on 07/12/17 at 11:01 AM. NA #5 stated she routinely took care of Resident #91 on first shift. She stated that Resident #91's shower days were Monday and Thursday and she	F 242	residents' personal preference interviews on 8/9/17 to ensure current resident preferences are being honored and any changes to residents' preference were noted and resident Kardex updated at this time. Admission Assistant completed new admission resident Personal Preference interview for accuracy. New admission resident's Kardex updated at this time to reflect current preference status. 3. Administrative Staff will be re-educated by 8/3/17 regarding resident preference interviews to include new residents and changes in current resident's preference status. The information obtained during these interviews will be brought to the IDT meeting, at which time any new or changed information will be noted on the resident's Kardex. 4. Resident Ambassadors (Department Heads) or designee will audit 10 residents to assure that resident care/preferences are reflective of their Kardex/personal preference's 3 times a week for 4 weeks and then weekly for 4 weeks. Personal preferences will be updated with quarterly care plans on-going. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI Committee by the Ambassadors (Department Heads) for 3 months at which time the committee will evaluate the effectiveness of the interventions and determine if further auditing is needed.	

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always went and never refused. NA #5 stated that she had to help Resident #91 wash her back and had to help her shave her legs but other than that she was relatively self-sufficient in the shower.

An interview was conducted with the Assistant Director of Nursing (ADON) on 07/13/17 at 3:58 PM. The ADON stated that everyone received a shower 2 times a week based on where their room was located. She added that she did not review the "Resident Preference Evaluation" sheet and was not sure who did. The ADON added that she would expect Resident #91's preferences to be honored as much as possible.

An interview was conducted with the DOA on 07/13/17 at 4:13 PM. The DOA stated that she had completed the Resident Preference Sheet as part of the ambassador program (customer service program at the facility). She added that currently the receptionist filled out the Resident Preference sheet. The DOA stated that when she had completed Resident #91's preference sheet she placed it in a notebook in the conference room and someone placed the information on the resident's kardex but she was not sure who was responsible for doing that. She added that maybe the MDS Nurse handled those.

An interview with the MDS Nurse #1 and Nurse #2 was conducted on 07/13/17 at 4:17 PM. Both MDS Nurse #1 and #2 stated that they had nothing to do with the Resident Preference Sheets, they knew that the sheets were located in a notebook in the conference room but did not who was responsible for the sheet or information on them.

An interview was conducted with the Receptionist

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F 242	Continued From page 26 on 07/13/17 at 4:20 PM. The receptionist stated that she obtained resident preferences when the resident admitted to the facility. Once the form was completed she placed the form in the notebook in the conference room and had no idea what was done with them after that. The Director of Nursing (DON) was unavailable for interview on 07/14/17 at 10:00 AM. An interview was conducted with the Administrator on 07/14/17 at 10:42 AM. The Administrator stated she expected that all resident preferences to be honored. An interview was conducted with the District Director of Clinical Services (DDCS) on 07/14/17 at 4:08 PM. The DDCS stated she expected all resident preferences to be honored by the facility staff.	F 242		
F 253 SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to repair broken and splintered laminate on resident room doors and a bathroom door on 4 of 12 resident rooms and 1 of 1 common bathroom door (Rooms 205, 401, 408 and bathroom on the 300 hall), failed to repair broken floor tile in 1 of 12 resident rooms (room 100), failed to repair patches on walls in 4 of 12 resident rooms (room 200, 202, 206, and 404) and failed to repair water damage on the ceiling	F 253	1. The tile in room 100 was replaced on 8/1/17. Divisional Director of Facility Engineering was notified of the immediate need for facility repairs as stated in the alleged deficiencies and that these repairs are to be corrected by 8/19/17. 2. Current residents have the potential to be affected by the alleged deficient practice. Maintenance Director and Divisional Director of Facility Engineering	8/19/17

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F 253	Continued From page 27 in 1 of 12 resident rooms (room 104). The Findings Included: 1. The following observations were conducted: a. Observation of room #205 on 7/10/17 at 11:06 AM revealed the door of the resident's bathroom was splintered and chipped with 2 holes on the upper 1/3 of the bathroom door. Observation of room #205 on 7/11/17 at 11:21 AM revealed the door of the resident's bathroom was splintered and chipped with 2 holes on the upper 1/3 of the bathroom door. Observation of room #205 on 7/12/17 at 2:19 PM revealed the door of the resident's bathroom was splintered and chipped with 2 holes on the upper 1/3 of the bathroom door. Observation of room #205 on 7/14/17 at 3:32 PM revealed the door of the resident's bathroom was splintered and chipped with 2 holes on the upper 1/3 of the bathroom door. b. Observation of room #401 on 7/10/17 at 3:34 PM revealed the door of resident's room had broken and splintered laminate and wood on the edges. Observation of room #401 on 7/12/17 at 4:11 PM revealed the door of resident's room had broken and splintered laminate and wood on the edges. Observation of room #401 on 7/14/17 at 3:39 PM revealed the door of resident's room had broken and splintered laminate and wood on the edges.	F 253	and or designee completed a facility audit to identify areas in need of immediate repair. 3. Divisional Director of Facility Engineering will re-educate Maintenance Director and Staff regarding identifying splintered doors, holes in doors, ceiling and walls in need of repair and tiles that are chipped and/or broken. Staff are to complete a work order notification for such needed repairs and place in Maintenance Communication book and nurses stations. Maintenance Director/Designee will check maintenance communication book 5 x weekly and on Mondays to check for anything reported over the weekend. Shared Services Maintenance Team to assist with repairs as identified as a result of the audit. 4. Resident Ambassadors (Department Heads) and/or designee will complete weekly audits to identify areas of concern 4 times a week for four weeks and then 2 times a week for 2 weeks and then 1 time a week for 1 month. Administrator, Director of Maintenance and/or designee will complete weekly facility rounds to monitor progress of repairs of identified areas. Maintenance Director and/or designee to review communication notebook 4 times a week for 4 weeks. Data obtained during these audits will be analyzed for patterns and trends and this information will be reported to the Quality Assurance (QAPI) by the Maintenance Director and or designee for 3 months.	

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F 253	Continued From page 28 c. Observation of room #408 on 7/10/17 at 3:31 PM revealed broken and splintered laminate and wood on door of room and bathroom door. Observation of room #408 on 7/11/17 at 11:54 AM revealed broken and splintered laminate and wood on door of room and bathroom door. Observation of room #408 on 7/14/17 at 3:43 PM revealed broken and splintered laminate and wood on door of room and bathroom door. d. Observation of bathroom on 300 hall closest to the nurse's station on 7/10/17 at 9:08 AM revealed broken and splintered laminate and wood on the bottom of the door nearest the floor. Observation of bathroom on 300 hall closest to the nurse's station on 7/11/17 at 8:47 AM revealed broken and splintered laminate and wood on the bottom of the door nearest the floor. Observation of bathroom on 300 hall closest to the nurse's station on 7/14/17 at 3:28 PM revealed broken and splintered laminate and wood on the bottom of the door nearest the floor. e. Observation of room #100 on 7/11/17 at 11:16 AM revealed broken and chipped floor tile by the resident's door. Observation of room #100 on 7/11/17 at 4:42 PM revealed broken and chipped floor tile by resident's door. Observation of room #100 on 7/13/17 at 9:09 AM revealed broken and chipped floor tile by resident's door.	F 253		

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Observation of room #100 on 7/14/17 at 3:26 PM revealed broken and chipped floor tile by resident's door.

f. Observation of room #200 on 7/10/17 at 2:22 PM revealed patched holes in resident's room wall that had not been sanded or painted.

Observation of room #200 on 7/11/17 at 11:23 AM revealed patched holes in resident's room wall that had not been sanded or painted.

Observation of room #200 on 7/12/17 at 2:10 PM revealed patched holes in resident's room wall that had not been sanded or painted.

Observation of room #200 on 7/14/17 at 3:31 PM revealed patched holes in resident's room walls that had not been sanded or painted.

g. Observation of room #202 on 7/10/17 at 2:07 PM revealed patched holes in resident's room wall that had not been sanded or painted.

Observation of room #202 on 7/11/17 at 11:25 AM revealed patched holes in resident's room wall that had not been sanded or painted.

Observation of room #200 on 7/12/17 at 2:12 PM revealed patched holes in resident's room wall that had not been sanded or painted.

Observation of room #200 on 7/14/17 at 3:28 PM revealed patched holes in resident's room wall that had not been sanded or painted.

h. Observation of room #206 on 7/10/17 at 2:16 PM revealed patched holes in resident's room wall that had not been sanded or painted.

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Observation of room #206 on 7/11/17 at 11:27 AM revealed patched holes in resident's room wall that had not been sanded or painted.

Observation of room #206 on 7/12/17 at 2:21 PM revealed patched holes in resident's room wall that had not been sanded or painted.

Observation of room #206 on 7/14/17 at 3:35 PM revealed patched holes in resident's room wall that had not been sanded or painted.

i. Observation of room #404 on 7/10/17 at 10:38 AM revealed patched holes in resident's room wall that had not been sanded or painted.

Observation of room #404 on 7/11/17 at 11:56 AM revealed patched holes in resident's room wall that had not been sanded or painted.

Observation of room #404 on 7/14/17 at 3:41 PM revealed patched holes in resident's room wall that had not been sanded or painted.

j. Observation of room #104 on 7/11/17 at 11:17 AM revealed unrepaired, unpainted water stain over the window bed in the room.

Observation of room #104 on 7/11/17 at 4:43 PM revealed unrepaired, unpainted water stain over the window bed in the room.

Observation of room #104 on 7/13/17 at 9:11 AM revealed unrepaired, unpainted water stain over the window bed in the room.

Observation of room #104 on 7/14/17 at 3:28 PM revealed unrepaired, unpainted water stain over

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the window bed in the room.

An interview was conducted with the Maintenance Supervisor on 7/14/17 at 10:44 AM. He stated that the facility utilized a report slip program to make maintenance aware of any issues that needed attention. He reported the slip used is carbon copy and he turned one copy in to the Administrator and he kept the other. He stated he had kept all carbon copy requests for the past 7-8 months. The Maintenance Supervisor explained if someone mentioned a problem to him while he is walking down the hall he tried to remember the concern but encouraged all staff to complete the maintenance request slip and turn in. He reported that all nurse's stations had "catchment boxes" where staff were able to drop off the maintenance request cards. He continued, stating that he and his assistant also tried to make weekly rounds throughout the building as well but the main source of maintenance requests came from the maintenance request logs provided by the staff. The Maintenance Director stated there were no current, large repair projects occurring in the building but was aware there are "dents and dings" in some resident rooms and reported he and his assistant would begin repairing them in the near future.

Observations were conducted with the Maintenance Director, Housekeeping Director and the Administrator on 7/14/17 at 3:20 PM. The Maintenance Director stated he was unaware of the chipped and splintered doors and the water stain on the ceiling in room #104. He reported he knew about the unpainted, patched holes in the walls of the resident's rooms but was unable to provide a timetable he had to have them repaired.

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F 253	Continued From page 32 The Maintenance Director also stated he was aware of the broken tile in room #100 and had reported it to the Director of Nursing but no plans had been made at that point to repair the tile. Interview with the Administrator on 07/14/17 at 3:46 PM. She stated what was shown to her was unacceptable and that her expectation was that resident rooms to be in good repair and maintenance on the rooms were completed in a timely fashion. She reported she expected, doors to be in good operating order, patched holes to be painted, broken tile to be replaced and observed water stains to be addressed immediately.	F 253		
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.	F 280		8/19/17

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BRIAN CENTER HEALTH AND RETIREMENT	**752 E CENTER AVENUE MOORESVILLE, NC 28115**

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F 280	Continued From page 33 (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (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.	F 280		

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F 280	Continued From page 34 (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility failed to review and update the care plan for 2 of 3 residents. Residents #57 and Resident #69. The Care Plan for resident #57 was not updated after a fall which resulted in injury and hospitalization. The Care Plan for Resident #69 was not updated for prevention of pressure ulcer. 1. Resident #57 was admitted to the facility on 09/01/15 with diagnoses which included: dementia, hypertension, contractures of right and left knees, reduced vision due to glaucoma, and chronic asthma. The Minimum Data Set quarterly assessment dated 06/23/17 indicated that the resident required extensive assistance for bed mobility and positioning; and was dependent on staff for personal care and transferring from bed. Resident #57 was always incontinent of bowel and bladder functions. The assessment dated	F 280	1. Care plan for resident #57 revised on 7/14/17. Care plan for resident #69 updated on 7/10/17. 2. All resident with pressure ulcers have the potential to be affected by the alleged deficient practice. Wound Care RN completed an audit of care plans of residents with pressure ulcers to ensure compliance. Audit completed 7/31/17. No areas of concern noted. Current residents with reported falls have the potential to be affected by the alleged deficient practice. Audit of care plans for residents that sustained a fall in the last 30 days completed 7/31/17 by DON/ADON/Administrative RN to ensure care plan reflects fall intervention in place. No areas of concern noted. 3. Licensed Nursing staff will be re-educated on proper care plan	

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F 280	Continued From page 35 06/23/17 indicated that the resident was legally blind and moderately impaired cognitively. The Care Plan for Resident #57 risk for falls was initiated on 07/20/16 and included interventions for frequent incontinence care, monitoring positioning frequently, and therapy as needed. The care plan had revision date of 01/06/17 which included use of Hoyer lift and 2 assist for transfers. Care plan was reviewed on 05/31/17. Record review revealed Resident #57 had a fall from wheel chair on 06/11/17. The resident sustained a head injury and was admitted to the hospital. Review of progress note dated 06/14/17 was readmitted to the facility after hospitalization from 06/11/17 through 06/13/17. The progress note also stated that the resident had sustained a right frontal subdural hematoma. Record review revealed that Minimum Data Set quarterly assessment dated 06/23/17. An interview was conducted with MDS nurse who stated that care plan had not been reviewed or updated since Resident #57 had quarterly assessment dated 6/23/17. An interview was conducted with acting Director of Nursing on 07/14/17 at 12:30 PM. The director of Nursing stated it was her expectation that the care plan for the resident be updated when the resident had a change in condition. 2. Resident #69 was re-admitted to the facility on 06/15/17 with diagnosis that included: recent aspiration pneumonia, previous stroke with	F 280	implementation to include revision of new fall events, new and/or changed pressure ulcers, and initial care plan for new admissions/ re-admissions to facility. Education will be provided by DON and/or designee. 4. Administrative RN (DON,ADON,Unit Manager,Unit Coordinator) and/or designee will review all new fall events daily in IDT meeting for 4 weeks then weekly for 4 weeks. Administrative RN (DON,ADON,Unit Manager,Unit Coordinator) and /or designee will review all residents with pressure ulcers daily in IDT meeting for 4 weeks, then weekly for 4 weeks. Further monitoring in IDT meeting as events occur to ensure care plan reflects resident status. Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance (QAPI) for 3 months, at which time the QAPI committee will evaluate the effectiveness of the interventions to determine if further auditing is needed to sustain compliance ongoing.	

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F 280	Continued From page 36	F 280		

residual hemiplegia, and peripheral vascular disease.

Review of a skin assessment form dated 06/15/17 revealed Resident #69 had a reddened area on left heel.

Review of physician order summary dated 06/15/17 did not include orders for prevention of pressure ulcers.

Review of treatment administration record for June 2017 revealed wound care for left heel wound initiated 06/25/17.

Review of Evaluation and Management report by Wound Care Nurse Practitioner dated 06/27/17 revealed Resident #69 had an unstageable pressure ulcer on left heel which measured 7 centimeters in length, 6 centimeters in width and estimated depth of 0.2 centimeter. The wound documentation indicated the wound had excessive necrotic tissue and drainage.

Review of care plan initiated 09/07/16 revealed interventions for prevention of skin breakdown which included notification of MD of emerging wounds; provide wound care/preventive skin care per order; skin checks weekly; and turn and position frequently to decrease pressure. Review of care plan indicated review date was 04/17/17.

Review of record revealed a Minimum Data Set quarterly assessment dated 06/22/17.

An interview was conducted with MDS on 07/13/17 at 1:58 PM. The MDS nurse stated that the care plan for the resident had not been updated at the time of the readmission or the

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F 280	Continued From page 37 Quarterly assessment. An interview was conducted with acting Director of Nursing on 07/14/17 at 12:30 PM. The Director of Nursing stated it was her expectation that care plans be reviewed and updated when a resident's condition changed.	F 280		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, family, significant other, and staff interviews the facility failed to implement care plan interventions by not dressing a resident in clothes as instructed by the care plan for 1 of 4 sampled residents (Resident #69). The findings included: Resident #69 was admitted to the facility on 01/28/16 and was readmitted to the facility on 05/04/17 with diagnoses that included: history of cerebrovascular accident with hemiplegia, seizure disorder, contracture of right wrist and elbow, and others. Review of a care plan dated 09/07/16 and last revised on 05/05/17 read in part, Resident #69	F 282	1. NA #1 re-educated regarding adhering to resident's individual Kardex which reflects resident's care plan goals and personal preferences. Education completed on 7/17/17. 2. Current residents have the potential to be affected by the alleged deficient practice. All residents' Kardexes updated to reflect care plan goals and personal preferences by 8/9/17. 3. Staff (licensed, unlicensed, and administrative staff) will be re-educated regarding care plan goals and personal preferences being reflective on individual Kardex as well as proper utilization of Kardex. Education to be completed by 8/19/17. Any staff ot completing education by 8/19/17 will not work until education is	8/19/17

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F 282	Continued From page 38 required assistance with activities of daily living (ADLs) related to cerebrovascular accident. Resident #69 required extensive to total assistance from one to two staff members with all ADLs. The goal of stated care plan was Resident #69 would have ADL needs identified and met with staff assistance and interventions. The interventions of the stated care plan included: dress daily and no gowns. Review of the most recent quarterly minimum data set (MDS) dated 06/22/17 revealed that Resident #69 was severely cognitively impaired for daily decision making and had no speech. The MDS also revealed that Resident #69 required total assistance of 1 staff member for dressing and no rejection of care was noted during the assessment period. An observation of Resident #69 was made on 07/09/17 at 12:26 PM. Resident #69 was resting in bed and was dressed in a hospital gown. An observation of Resident #69 was made on 07/10/17 at 12:30 PM. Resident #69 was resting in bed and was dressed in a hospital gown. Review of Resident #69 kardex on 07/11/17 revealed the following: "dress only no gowns." An interview was conducted with Nursing Assistant (NA) #1 on 07/11/17 at 2:51 PM. NA #1 stated that she routinely cared for Resident #69 on first shift. She stated that she gave him a bed bath and placed a fresh gown on him daily. NA #1 stated that she left him in a gown "so he can rest better since he did not get out of bed." NA #1 added that the facility had a kardex book at the nurse's station that they could refer to if they	F 282	completed. 4. Resident Ambassadors (Department Heads) and/or designee will monitor residents to ensure residents daily care is reflective of resident's individual Kardex (care plan goals and personal preferences). MDS will audit 10 residents a week for 4 weeks, then 5 resident a week for 4 weeks, and then 2 residents a week for 4 weeks. Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance (QAPI) by the Resident Care Management Director for 3 months, at that time the QAPI committee will evaluate the effectiveness of the interventions to determine if auditing is necessary to maintain compliance.	

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F 282	Continued From page 39	F 282		

needed any information about the residents. NA #1 stated she had not reviewed the kardex for Resident #69 today, "if anything changed with him they usually let me know."

An observation of Resident #69 was made on 07/11/17 at 3:43 PM. Resident #69 was resting in bed and was dressed in a hospital gown.

An interview with Resident #69's family was conducted on 07/12/17 at 9:31 AM. The family member stated that he visited Resident #69 several times a week and when he visited Resident #69 was always in the bed and in a hospital gown. The family member stated that the facility was supposed to dress him every day and he had plenty of clothes in his closet and there was no excuse why he was not dressed.

An interview with Resident #69's significant other was conducted on 07/13/17 at 8:54 AM. She stated she visited with Resident #69 several times a week and when she visited Resident #69 was always in a hospital gown. The significant other stated that Resident #69 was a truck driver and he was up and dressed every single day and he would not want to stay in a hospital gown and in the bed all the time.

The Assistant Director of Nursing (ADON) was unavailable for interview on 07/14/17 at 10:00 AM.

The Director of Nursing (DON) was unavailable for interview on 07/14/17 at 10:00 AM.

An interview was conducted with the Administrator on 07/14/17 at 10:32 AM. The Administrator stated that she expected the staff

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F 282	Continued From page 40 follow and implement all care plan interventions. An interview was conducted with the District Director of Clinical Services (DDCS) on 07/14/17 at 4:04 PM. The DDCS stated the staff was expected to follow and implement all care plan interventions. If Resident #69's care plan stated he was supposed to be dressed and not in a hospital gown then she expected Resident #69 to be dressed in regular clothes.	F 282		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review, family, and staff interviews the facility failed to trim and clean a dependent residents fingernails for 1 of 5 residents sampled for activities of daily living (Resident # 69). The findings included: Resident #69 was readmitted to the facility on 05/04/17 with diagnoses that included: cerebrovascular accident with hemiplegia, seizure disorder, contracture of right wrist and elbow, and others. Review of the most recent quarterly minimum data set (MDS) dated 06/22/17 revealed that Resident #69 was severely cognitively impaired for daily decision making. The MDS also revealed that Resident #69 required total assistance of 1	F 312	1. Resident #69's nails trimmed on 7/14/17. NA #1 was re-educated on 7/16/17 in regards to lengthy fingernails and cleanliness of residents' fingernails. 2. All dependent residents (residents with an ADL score of 10 or greater) have the potential to be affected by the alleged deficient practice. Nurse Manager completed an audit of all dependent residents' fingernails on 7/16/17 to ensure cleanliness of nails and that nails were trimmed. 3. Nursing staff will be educated on proper cleanliness and trimming of lengthy fingernails of dependent residents by 8/19/17. 4. Department Managers and/or designee will audit 5 dependent residents (resident's with and ADL score of 10 or	8/19/17

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F 312	Continued From page 41 staff member for personal hygiene. An observation of Resident #69 was made on 07/09/17 at 12:26 PM. All of Resident #69's fingernails were noted be a quarter inch long and had dried brown substance under them. An observation of Resident #69 was made on 07/10/17 at 12:30 PM. All of Resident #69's fingernails were noted to be a quarter inch long and had dried brown substance under them. An interview and observation was conducted on 07/11/17 at 2:51 PM with Nursing Assistant (NA) #1. NA #1 stated she routinely cared for Resident #69 on first shift. She stated that she had bathed Resident #69 this am and she had not noticed that his nails needed to be trimmed but after looking at them confirmed that they "definitely need to be trimmed and cleaned." NA #1 added that she checked fingernails every other day and had just not noticed Resident #69's but she would take care of them right away. An observation of Resident #69 was made on 07/11/17 at 3:43 PM. All of Resident #69's fingernails were noted to be a quarter inch long and had dried brown substance under them. An interview and observation was conducted on 07/12/17 at 9:31 AM with Resident #69's family member. Resident #69's family member confirmed that Resident #69's fingernails needed to be trimmed and cleaned. An observation of Resident #69 was made on 07/12/17 at 9:38 AM. All of Resident #69's fingernails were noted to be a quarter inch long and had dried brown substance under them.	F 312	greater) to ensure lengthy fingernails are trimmed and nails are clean 4 times a week for 4 weeks, then 2 times a week for 2 weeks and then 1 time a week for 1 month. Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance Performance Improvement (QAPI) team by the Administrator for 3 months, at which time, the QAPI Committee will evaluate the effectiveness of the interventions to determine if additional auditing is necessary to maintain compliance.	

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F 312	Continued From page 42 A follow up interview was conducted with NA #1 on 07/13/17 at 10:24 PM. NA #1 stated she had not had the time to go back to clip or clean Resident #69's fingernails. NA #1 added she would take care of it right away. An observation of Resident #69 was made on 07/13/17 at 10:32 AM. All of Resident #69's fingernails were noted to be a quarter inch long and had dried brown substance under them. An observation of Resident #69 was made on 07/14/17 at 9:52 AM. All of Resident #69's fingernails were noted to be a quarter inch long and had dried brown substance under them. The Assistant Director of Nursing (ADON) was unavailable for interview on 07/14/17 at 10:00 AM. The Director of Nursing (DON) was unavailable for interview on 07/14/17 at 10:00 AM. An interview was conducted with the Administrator on 07/14/17 at 10:32 AM. The Administrator stated that she expected the staff to cut, clean, and trim residents fingernails and toenails as needed. An interview was conducted with the District Director of Clinical Services (DDCS) on 07/14/17 at 4:04 PM. The DDCS stated the staff was expected to check fingernails on a daily basis and trim and clean them as needed.	F 312		
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		8/19/17

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F 314	Continued From page 43 (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, staff and family interviews the facility failed to assess and provide treatment to prevent development of pressure ulcer for one of four sampled residents (Resident # 69). The resident was readmitted on 06/15/17 to the facility with a reddened area on left heel. The area on the left heel was not reassessed until 06/25/17 at which time the left heel area was black in color. The findings included: Resident #69 readmitted to the facility with diagnoses that included: recent aspiration pneumonia, previous stroke with residual hemiplegia, peripheral vascular disease. The Minimum Data Set assessment dated 06/22/17 for the quarterly assessment indicated that resident #69 was severely impaired cognitively. The resident also required extensive assistance	F 314	1. Treatment order for resident #69 implemented on 6/25/17. Resident assessed by Wound Care Specialist NP on 6/27/17 and new treatment orders initiated. 2. All residents with pressure ulcers have the potential to be affected by the alleged deficient practice. Administrative RN(DON,ADON,Unit Manager,Unit Coordinator) completed an audit of all residents to ensure treatment orders were in place and Practitioner notification occurred. Audit completed 8/4/17. New admissions were reviewed the day after admission, or on Monday following weekend admission for treatment orders for pressure ulcers as indicated. MD made aware of any areas of change if necessary. 3 .Licensed nursing staff will be	

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F 314	Continued From page 44 for bed mobility/positioning and transfers from bed. He was dependent for all personal care. The resident received nutrition through a feeding tube and was dependent on supplemental oxygen. Review of physician order summary dated 06/15/17 at time of re-admission to the facility did not include orders for prevention of pressure ulcers. Review of skin assessment form dated 6/15/17 revealed resident had reddened areas on left heel. Review of treatment administration record for June 2017 revealed wound care for left heel wound initiated 06/25/17 with use of skin protective wipe. Review of Evaluation and Management report by Wound Care Specialist dated 06/27/17 revealed resident had an unstageable pressure ulcer on left heel which measured 7 centimeters in length, 6 centimeters in width and estimated depth of 0.2 centimeter. The wound was documented as having excessive necrotic tissue and drainage. Treatment ordered included Silver-alginate dressing and prevention of pressure on the wound area. Review of Wound Management report by Wound Care Specialist dated 07/11/17 revealed left heel wound was Stage III pressure ulcer and contained necrotic tissue. The wound care treatment order was changed to Santyl to enzymatically debride necrotic tissue. An observation of Nurse #3 was made on	F 314	re-educated by DON/ADON by 8/19/17. Education to include skin management, treatment initiation, and Practitioner notification of new and/or change in pressure ulcers. Administrative RN (DON, ADON, Unit manager, Unit Coordinator) will review new admission skin assessments in IDT meeting the following day of admission or on Monday following a weekend admission to ensure any areas noted have active treatment and Practitioner notification. IDT will review new admission skin assessments on going. 4. Administrative RN(DON,ADON,Unit Manager,Unit Coordinator) and or designee will review facility all pressure areas to ensure treatment in place, Practitioner notification occurred and any changes to pressure area 4 times a week for 4 weeks, then 2 times a week for 2 weeks, and then 1 time a week for 1 month. . Nurse Manager and/or designee will continue to assess all pressure areas for changes, treatment and notification weekly for 3 months. Data obtained during the audit process will be analyzed for patterns and trend and reported to Quality Assurance (QAPI) for 3 months, at which time the QAPI committee will evaluate the effectiveness of the interventions and make recommendations to determine if further auditing is needed to sustain compliance on going.	

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07/12/17 at 11:24 AM performing wound care on left heel of Resident #69. The old dressing observed to have red and watery yellowish drainage on it. The wound had an area of greyish tissue surrounded with pink tissues. The edges of the wound had darkened, flaky skin. The wound was cleaned and Santyl ointment applied, and the area on left heel covered with dry dressing.

An interview was conducted on 07/13/17 with Nurse #2 at 11:25 AM who had performed assessment at time of readmission. Nurse # 2 stated that Resident #69 had a reddened area on left heel at the time of skin admission assessment was completed on 06/15/17. Nurse #2 also stated that measurements and description of the area had not been entered on the form entitled Nursing Admission Data Collection form in the area for Skin assessment. During the interview with Nurse #2 it was stated that referral had not been made to the Wound Treatment registered nurse for assessment of the reddened area on the left heel of Resident #69. Nurse #2 confirmed that the medical record did not include a reassessment of the left heel during the week of 06/18/17 through 06/24/17.

An interview was conducted with a family member on 07/13/17 at 1:20 PM who stated that he had been informed on 06/25/17 that Resident #69 had been referred to Wound Care Specialist. The family member stated that he had observed the resident on 06/25/17 with a blackened area on his left heel and did not have protective boots on either the right or left foot. The family member reported that the left heel was turned inward and rested against the heel of the right foot when observed on 06/25/17.

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F 314	Continued From page 46 An interview was conducted on 7/13/17 at 3:18 PM with Nurse #3 who functioned as wound care/treatment nurse. Nurse #3 stated that it was her expectation to be notified when a resident had a reddened area on skin. Nurse #3 also stated that she had been notified about the left heel wound on 06/25/17 and she observed the wound was black in color. Nurse #3 stated that a referral had been made to the Wound Specialist who did initial assessment of left heel wound on 06/27/17. On 07/14/17 at 11:07 AM an interview was conducted with Wound Care Specialist who stated that she had first evaluated wound on 06/27/17. The Wound Care Specialist stated during that interview that the wound on the left heel of Resident #69 had been a blackened, opened, but unstageable wound when first evaluated. The Wound Care Specialist stated that after treatment the wound was assessed as a Stage III pressure ulcer on 07/11/17. On 07/14/17 at 3:51 PM an interview was conducted with the Assistant Director of Nursing (ADON) because the Director of Nursing was not available. The ADON stated it was the expectation that wound assessments be completed and include measurements and description of areas of reddened skin observed by nursing staff. It was also stated by ADON that it was her expectation that wound care/treatment registered nurse be notified if a resident developed reddened skin area.	F 314		
F 318 SS=D	483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION	F 318		8/19/17

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F 318	Continued From page 47 (c) Mobility. (2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. (3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, family, and staff interviews the facility failed to apply physician ordered splints to prevent worsening contractures for 1 of 1 residents sampled for range of motion (Resident #69). The findings included: Resident #69 admitted to the facility on 01/28/16 and was readmitted to the facility on 05/04/17 with diagnoses that included: history of cerebrovascular accident with hemiplegia, seizure disorder, contracture of right wrist and elbow, and others. Review of Resident #69's care plan dated 09/16/16 and last revised on 05/05/17 revealed no care plan for application of splints or devices. Review of Physical Therapy (PT) discharge summary dated 01/16/17 indicated that Resident #69 had increased his right knee extension to -55 (hyper-flexion) degrees from neutral to assist with his positioning and was tolerating his right knee orthotic (splint) for 6 hours without signs of	F 318	1. PT and OT evaluation completed on 7/11/17 for resident #69 to evaluate the need for continued orthopedic devices. 2. Current residents with orthopedic devices have the potential to be affected by the alleged deficient practice. Evaluation of all residents with current orders for orthopedic devices will be completed by therapy on 8/19/17. 3. Nursing Staff (licensed and Unlicensed) will be educated by the Rehab Program Manager (RPM) on the proper donning and removal of orthopedic devices and the identification of potential worsening contractions. 4. Nurse Manager (DON, ADON, Unit Manager, Unit Coordinator) will audit 5 residents with splints 4 times a week for 4 weeks, then 2 times a week for 2 weeks, and then weekly for 1 months to ensure orthopedic device application is per physician's order. Data obtained during the audit process will be gathered and analyzed for patterns and trends. The information will be	

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F 318	Continued From page 48 redness or skin breakdown to maintain his maximal range of motion (ROM). The recommendations at discharge were right knee orthotic up to 8 hours per day. Review of an Occupational Therapy (OT) discharge summary dated 01/25/17 indicated that Resident #69 had improved his right upper extremity elbow passive range of motion to 125 degrees which increased the comfort of the right elbow splint. The recommendation at discharge was right elbow splint on in the morning and off at bedtime. Review of a physician order dated 05/15/17 read in part, right elbow splint on in the morning and off at bedtime. Perform skin integrity checks before application and after removal every day and evening shift. Review of a physician order dated 05/15/17 read in part, right knee splint on in the morning and off at bedtime. Perform skin integrity checks before application and after removal every day and evening shift. Review of the most recent quarterly minimum data set (MDS) dated 06/22/17 revealed that Resident #69 was severely cognitively impaired for daily decision making. The MDS also revealed that Resident #69 required extensive to total assistance of 1 to 2 staff members for all activities of daily living. It also revealed no rejection of care was noted during the reference period. The MDS further revealed that no restorative nursing programs were in place. Review of treatment administration record (TAR) dated July 2017 revealed the following: Right	F 318	reported to Quality Assurance (QAPI) at which time the committee will be evaluate the effectiveness of the interventions and determine the need for further auditing in order to sustain compliance.	

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knee splint on in the morning and off at bedtime. The right knee splint had been initialed indicating that it had been applied on each date except 07/02/17, 07/03/17, 07/05/17, 07/06/17, 07/08/17, and 07/10/17. The TAR also contained Right elbow splint on in the morning and off at bedtime. The right elbow splint had been initialed indicating that it had been applied on each date except: 07/02/17, 07/03/17, 07/04/17, 07/05/17, 07/06/17, 07/07/17, and 07/08/17.

An observation of Resident #69 was made on 07/09/17 at 12:26 PM. Resident #69 was resting in bed and no right elbow or right knee splints were in place. Both splints were noted to be lying on top of the oxygen concentrator next to his bed.

An observation of Resident #69 was made on 07/10/17 at 12:30 PM. Resident #69 was resting in bed and no right elbow or right knee splints were in place. Both splints were noted to be lying on top of the oxygen concentration next to his bed.

Review of physician order dated 07/10/17 read in part, discontinue right knee splint on in the morning and off at bedtime due to non-use.

An observation of Resident #69 was made on 07/11/17 at 3:43 PM. Resident #69 was resting in bed and no right elbow splint was in place. The right elbow splint was noted to be lying on top of the oxygen concentrator next to his bed.

Review of physician order dated 07/11/17 read in part, discontinue right elbow splint on in the morning and off at bedtime.

Review of PT evaluation and plan of treatment for

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Resident #69 dated 07/11/17, read in part Resident #69's right knee extension was currently at -45 degrees.

An interview was conducted with the PT on 07/11/17 at 2:41 PM. The PT stated that this was his first day working at the facility and he was instructed to evaluate Resident #69. The PT stated that during his evaluation Resident #69 had -44 degrees of flexion in the right knee and he was able to get to -38 degrees with gentle stretching.

An interview was conducted with Nursing Assistant (NA) #1 on 07/11/17 at 2:51 PM. NA #1 stated she routinely cared for Resident #69 on the day shift and had been caring for him for the past several weeks and she had never applied splints to Resident #69. She stated she took care of Resident #69 on 07/10/17 and 07/11/17 and did not apply any splints to him. She added that PT and restorative nursing would usually apply splints but she had never seen Resident #69 wear any splints. NA #1 added that she had not received any training on any splint application or removal for Resident #69.

An interview was conducted with the Occupational Therapist (OT) on 07/11/17 at 3:13 PM. The OT stated that she had evaluated Resident #69 on 07/11/17 for the continued need of his orthotic devices and he was noted to have no active range of motion and very limited passive range of motion in all upper extremity joints. She added that on 07/11/17 Resident #69 had 59 degrees of shoulder extension/flexion and the right elbow had -50 degrees of elbow extension. The OT added that Resident #69 had a decline in overall condition and that was what

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prompted the re-evaluation for therapy.

Review of Resident #69's kardex on 07/11/17 revealed nothing about splint application or removal.

An interview with Resident #69's family was conducted on 07/12/17 at 9:31 AM. The family member stated that he visited Resident #69 several times a week and when he visited his right elbow splint and right knee splint were never on him, they were usually lying on top of the oxygen concentrator next to his bed.

An interview with Resident #69's significant other was conducted on 07/13/17 at 8:54 AM. She stated that the facility did not apply Resident #69's right elbow or right knee splint like they were ordered. She stated she visited with Resident #69 several times a week and when she visited the splints were noted to be lying on top of the oxygen concentrator next to his bed.

An interview was conducted with NA #4 on 07/14/17 at 9:54 AM. NA #4 stated that he was taking care of Resident #69 and that he was not aware of any splints that were ordered for Resident #69. He stated that he would have to clarify with the therapy department before he took Resident #69 to the shower about any splints that needed to be applied and when to remove them.

The Assistant Director of Nursing (ADON) was unavailable for interview on 07/14/17 at 10:00 AM.

The Director or Nursing (DON) was unavailable for interview on 07/14/17 at 10:00 AM.

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F 318	Continued From page 52 An interview was conducted with the Administrator on 07/14/17 at 10:32 AM. The Administrator stated she expected all physician ordered splints to be applied as ordered. An interview was conducted with the District Director of Clinical Services (DDCS) on 07/14/17 at 4:04 PM. The DDCS stated she expected all physician ordered splints to be applied and removed as ordered.	F 318		
F 329 SS=D	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 (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--	F 329		8/19/17

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F 329	Continued From page 53 (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 medical record review, staff, Psychiatric Physician Assistant (PPA) and physician interviews, the facility failed to obtain laboratory tests for medication management as ordered by the physician for 2 of 4 residents (Resident #118 and Resident #145) reviewed for unnecessary medications. Findings included: 1. Resident #118 was admitted to the facility on 05/09/17 with multiple diagnoses that included traumatic brain injury, unspecified psychosis, seizure disorder, and dementia. A review of the psychiatric progress note dated 05/31/17 for Resident #118 revealed a recommendation to obtain "Valproic Acid level STAT (immediate)." A review of the laboratory test results obtained on 05/31/17 for Resident #118 revealed the reference range for Valproic Acid should be between 50.0 and 100.0. The results recorded Resident #118's Valproic Acid level as 111.5	F 329	1. Valproic Acid level was obtained for resident #118 on 7/10/17. Valproic Acid level was obtained for resident #145 on 6/30/17. MD was made aware of lab results. Any new orders obtained were processed. Nurse #3 was re-educated on physician order processing which included lab orders/entry. 2. Current residents on Depakote have the potential to be affected by the alleged deficient practice. An audit of residents on Depakote was conducted to ensure laboratory testing completed as ordered. Audit completed 8/7/17. No areas of concern noted. 3. Licensed Nurses will be re-educated by DON/ADON by 8/19/17 on the current procedure of lab ordering and MD order processing. 4. Administrative RN (DON,ADON,Unit Manager, Unit coordinator) or designee will audit 10 lab orders 4 times a week for 4 weeks, then 4 times a week for 2 weeks, and then weekly times one month to ensure lab order/processing and	

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F 329	Continued From page 54 which was high. A handwritten note signed by Nurse #3 read in part, "reported to MD. Recheck Monday 06/12/17." A review of the physician telephone orders for Resident #118 revealed an order dated 05/31/17 that read in part, "recheck Ammonia 06/12/17." There was no order to obtain a Valproic Acid on 06/12/17. A review of Resident #118's medical record revealed no evidence that a Valporic Acid was drawn on 06/12/17. An interview was conducted with Nurse #3 on 07/12/17 at 12:06 PM. Nurse #3 confirmed she had reported Resident #118's laboratory test results to the physician on 05/31/17 who had given her the verbal order to recheck on 06/12/17. Nurse #3 stated she had written the order to obtain an Ammonia laboratory test as instructed by the physician but had forgot to include the Valproic Acid laboratory test on the order. Nurse #3 reviewed the lab requisition for Resident #118 which indicated Valproic Acid tests were completed on 05/24/17, 05/31/17 and 07/10/17. Nurse #3 confirmed no Valproic Acid had been obtained for Resident #118 during the month of June. A telephone interview with the PPA on 07/13/17 at 3:55 PM revealed he reviewed Valproic Acid levels for residents receiving Depakote medication in order to determine if the medication needed to be adjusted. The PPA confirmed he had ordered the STAT Valproic Acid on 05/31/17 prior to making any adjustments to Resident #118's medication. The PPA explained a level of 111.5 was high and would need to be monitored	F 329	implementation and MD notification occurred. Data obtained during this audit process will be analyzed for patterns and trends and reported to Quality Assurance (QAPI) by Nurse Manager for 3 months at which time the committee will evaluate the effectiveness of the interventions and determine if further auditing is necessary to sustain compliance ongoing.	

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by the physician so the correct dosage of Depakote medication could be determined and administered appropriately.

A joint interview was conducted with the Administrator and District Director of Clinical Services on 07/14/17 at 4:49 PM. The Administrator stated she would expect for staff to obtain laboratory tests as ordered by the physician.

A telephone interview was conducted with the Medical Director on 07/14/17 at 5:44 PM who stated laboratory tests should be obtained as ordered.

2. Resident #145 was admitted to the facility on 04/27/17 with diagnoses that included stroke, seizure disorder, anxiety disorder, and depression.

A review of the psychiatric progress note dated 05/31/17 for Resident #145 revealed a recommendation to increase Depakote to 500mg at bedtime and obtain a "Valproic Acid level in 2 weeks" which would have been due on 06/14/17.

A review of the physician telephone orders revealed an order dated 06/01/17 that read "increase Depakote to 500mg at bedtime. Continue Depakote 250mg every morning." There was no order to obtain a Valproic Acid on 06/14/17.

A review of Resident #145's medical record revealed no evidence that a Valproic Acid was drawn on 06/14/17.

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An interview was conducted with Nurse #3 on 07/14/17 at 9:52 AM. Nurse #3 explained for each facility visit the PPA provided her with a list of residents seen along with his recommendations. Nurse #3 stated the physician would review the recommendations and if she agreed, an order would be written. Nurse #3 verified the physician had agreed with the PPA's recommendations from his visit with Resident #145 on 05/31/17 to check the Valproic Acid in two weeks which would have been due on 06/14/17. Nurse #3 confirmed she had written the order to increase Resident #145's medication as recommended but forgot to include the Valproic Acid laboratory test on the order. Nurse #3 provided a requisition from the laboratory which indicated the only Valproic Acid tests completed for Resident #145 were on 06/30/17 and 07/13/17.

A telephone interview with the PPA on 07/13/17 at 3:55 PM revealed he reviewed the Valproic Acid levels for residents receiving Depakote medication in order to determine if the medication needed to be adjusted. The PPA explained Valproic Acid levels needed to be monitored by the physician so the correct dosage of Depakote medication could be determined and administered appropriately.

A joint interview was conducted with the Administrator and District Director of Clinical Services on 07/14/17 at 4:49 PM. The Administrator stated she would expect for staff to obtain laboratory tests as ordered by the physician.

A telephone interview was conducted with the Medical Director on 07/14/17 at 5:44 PM who

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F 329	Continued From page 57 stated laboratory tests should be obtained as ordered.	F 329		
F 353 SS=G	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of	F 353		8/19/17

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F 353	Continued From page 58 duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, family and staff interviews the facility failed to have sufficient quantity of staff to ensure a dependent resident was provided pressure ulcer care, nail care, and had splints applied to prevent further contractures (Resident #69) for 1 of 4 sampled residents. The findings included: 1. Cross reference F-224: Based on observation, record reviews, staff and family interviews the facility neglected to assess and provide treatment for pressure ulcer and neglected to clean and trim a dependent residents finger nails for 1 of 3 residents. (Resident # 69). The facility neglected to assess and seek treatment for Resident #69 which resulted in a decline of the pressure ulcer condition from redness upon admission on 06/15/17 to black necrotic tissues on 06/25/17. 2. Cross reference F-314:	F 353	1. Resident #69 was assessed and began receiving treatment to pressure area on 6/25/17. Resident #69□s fingernails were cleaned and trimmed on 7/14/17. Therapy evaluation of resident #69 completed on 7/11/17 to assess the need for further use of splints. Resident currently on therapy case load. 2. Facility currently has contracts with two staffing agencies to ensure sufficient staffing needs are met. Active staff recruiting continues with outside resources, walk-in applicants and referrals. 3. Licensed and unlicensed staff re-educated on ROM, ADL care (to include clothing per personal preference, and nail care), abuse and neglect, and assessing and treatment of pressure areas by the Administrative RN(DON, ADON,Unit Manager, Unit Coordinator) or designee. Education completed by 8/19/17. 4. Administrative staff or designee will audit dependent residents (residents with	

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F 353	Continued From page 59 Based on observation, record review, staff and family interviews the facility failed to assess and provide treatment to prevent development of pressure ulcer for 1 of 4 sampled residents (Resident #69). The resident was readmitted on 06/15/17 to the facility with reddened area on left heel. The area on the left heel was not reassessed until 06/25/17 at which time the left heel was black in color. 3. Cross reference F-312: Based on observations, record review, family, and staff interviews the facility failed to trim and clean a dependent residents fingernails for 1 of 5 residents sampled for activities of daily living (Resident # 69). 4. Cross reference F-318: Based on observations, record reviews, family, and staff interviews the facility failed to apply physician ordered splints to prevent worsening contractures for 1 of 1 residents sampled for range of motion (Resident #69). An interview was conducted with a family member of Resident #69 on 07/12/17 at 9:31 AM. The family member stated there was not enough staff in the facility to take care of his family member. The family member stated that the facility did not dress his family member like they were supposed to and they did not have enough staff to trim his fingernails or put lotion on his skin. The family member stated that there was not enough staff to put his loved ones splints on, "they are always lying next to the bed" but were not on the resident.	F 353	an ADL score of 10 or greater) to ensure lengthy fingernails are trimmed and nails are clean 3 times a week for 4 weeks then 2 times a week for 2 weeks and then weekly for 1 month to ensure orthopedic device application is per physician order. Nurse Manger will audit 5 residents with splints 4 times a week for 4 weeks, then 2 times a week for 2 weeks, weekly time one month. Administrative RN(DON,ADON,Unit Manager,Unit Coordinator) and or designee will review facility pressure areas to ensure treatment in place, Practitioner notification occurred and any changes to pressure area 4 times a week for 4 weeks, then 2 times a week for 2 weeks then 1 time a week for 1 month. Administrator/DON and/or designee will review staffing needs 5 x weekly during IDT meetings and will continue to seek qualified candidates. Data obtained during this audit process will be analyzed for patterns and trends and reported to Quality Assurance (QAPI)by DON/ADON for 3 months.	

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An interview was conducted with Nurse #1 on 07/12/17 at 6:30 PM. Nurse #1 confirmed that she was actually the unit manager at the facility. She stated that staffing was an on-going issue. Nurse #1 stated that she recalled in June 2016 more specifically the weekend of June 17-18, 2017 she was the supervisor and was dealing with alot of staffing issues. She indicated that the facility had a couple of call outs and they were working short and it was a busy weekend with lots of extra visitors. Nurse #1 stated she had some very upset family members because they discovered their loved ones were soiled and disheveled when they came to visit. She added that she was trying to get the staff that was available in the correct location so that all the residents could get cared for adequately. Nurse #1 stated she was relatively new to the facility and she had taken the family ' s member concerns and placed them on concern form and given them to the Director of Nursing for follow up. Nurse #1 stated that she felt like that weekend the staff "could have done a better job" of taking care of the residents.

An interview was conducted with Nurse #9 on 07/14/17 at 6:11 AM. Nurse #9 stated that at times the staff had to work short staffed due to call outs. She added when there were short staffed everyone had to pull together to get things done. Nurse #9 stated that when a staff member called out she would let the facility scheduler know and she would try to find a replacement which was not always possible.

An interview was conducted with NA #8 on 07/14/17 at 6:22 AM. NA#8 stated that at times the facility was short staffed due to call outs. She added that sometimes they were able to replace

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the call out but at times they were not. When they were short staffed NA #8 stated they all had to pull together to get the care done. She added that the care was "usually provided but we have to do each round more quickly" to get it all done and could not spend good quality time with residents.

An interview was conducted with Nursing Assistant (NA) #6 on 07/14/17 at 6:23 AM. NA #6 stated that staffing at night "was not good and it is getting worse." She stated she had worked night shift for 13 years and she worked a lot of overtime hours in stressful situations. NA #6 stated that she had to rush through her assignment and did not get to spend any time with the residents.

An interview was conducted with NA #7 on 07/14/17 at 6:30 AM. NA #7 indicated he was agency staff. NA #7 stated that at times staffing was "iffy" and during those times they really have to pick up the slack and had to hurry to get everything completed before the end of the shift. He added that usually there were 3 NAs on the 300 hall but due to a call out on 07/14/17 it was just him and another NA on the 300. He stated "I guess they could not find anyone to work."

The Director of Nursing (DON) was unavailable for interview.

An interview was conducted with the Administrator on 07/14/17 at 10:59 AM. The Administrator stated she had only been at the facility for 2 weeks and she really "did not know anything about staffing." She stated that she routinely asked about staffing in the facility's morning meeting and nothing had been brought to her attention. She added that she was not

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aware if call-outs were a big issue at the facility or not and she had not been their long enough to assess the situation. The Administrator stated that when she questioned the DON about staffing she was always told "it was fine." She also stated she was aware that the facility currently used agency staff and she did not want to use them long term. The Administrator added she was not aware if call-outs were replaced or not but her expectation was that the facility was staffed appropriately to meet the needs of the residents.

An interview was conducted with the District Director of Clinical Services (DDCS) on 07/14/17 at 4:03 PM. The DDCS stated she expected the facility to be staffed to meet all the needs of all the residents.

An interview was conducted with the scheduler on 07/14/17 at 4:12 PM. The Scheduler explained that she staffed the building based on resident to NA ratios. Those ratios were as followed: 1st shift no more than 12 residents to 1 NA, 2nd shift no more than 14 residents per NA, and 3rd shift no more than 25 residents per NA. So the number of staff needed changed on a daily basis as the census changed. The scheduler stated that they used a computer software call "on shift" and when there was a call-out, a message was sent out to all available NAs alerting them. She also added that she would send out text to staff members to see if anyone wanted to work. The scheduler stated she did a good job of making sure all the call-outs were covered. She added that the ADON monitored the call-outs and disciplinary action was taken after a certain number of call outs. The scheduler stated that she currently had 8 full time NA positions and 4 full time nurse positions. She also added that she

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F 353	Continued From page 63 was a NA and at times she covered call-outs or open shifts if needed. She explained that the facility contracted with 2 staffing agencies and she would call them and tell what the needs of the facility were. The scheduler felt like the 2 staffing agencies were able to adequately meet the needs of the facility. She did say that the facility had some turn over recently and they just could not hire new staff quick enough to replace those that left. She added that the facility was currently running an advertisements for new staff and was offering a sign on bonus for new staff. She added that the staff was able to complete their assignment and still get their lunches. She was unaware of any care that was not being completed due to the shortage of staff.	F 353		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 371		8/19/17

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F 371	Continued From page 64 (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to keep flies out of the kitchen area during food production and meal service, failed to discard opened containers of milk that were not dated when opened and failed to remove 3 cartons of ice cream from the floor of the walk in freezer. Findings included: On 07/12/17 the lunch meal service was observed with the Food Service Director and the District Dietary Manager. On 07/12/17 at 11:40 AM observations were made at the food preparation table located behind the steam table and Cook #1 swatted at a fly with an oven mitt while she checked the temperature of food before she placed the food in the steam table. On 07/12/17 at 12:04 PM Cook #1 started plating food for residents and a fly was observed flying around the food preparation table behind the steam table. The steam table was observed to have uncovered food items that included chicken patties, noodles, marinara sauce, black beans and rice, cooked carrots, meat patties, gravy, ground meat, pureed vegetables and pureed noodles. A container of grated mozzarella cheese was sitting on a table next to the steam table and was partially uncovered with plastic wrap. On 07/12/17 at 12:21 PM a metal cart of meal trays was taken through a door to the main dining room. Continuous observations on	F 371	Pest Control 1. The plastic wrap covering the cheese garnish was removed and replace with new wrap. 2. At the conclusion of meal service, all prep tables were washed with soap and water and sanitized with chemical sanitizer. The dietary manager wrote a maintenance request on 7/14/2017 to have bug lights installed in the kitchen. 3. Dietary staff was in-serviced to report any pest sightings in the maintenance log. Completed 7/31/2017 4. The dietary staff will monitor for presence of pests 3 times per day during meal service for 2 weeks , then 1 time per day during meal service for 2 weeks , then 3 times a week during meal service for 4 weeks, then 1 time a week during meal service for 4 weeks. The dietary manager will report the results at QA for 3 months. Food Storage 1. Open milks were discarded from the refrigerator. Ice cream cups were removed from the freezer floor and discarded. 2. All refrigerators were checked for proper food storage. Any items not stored properly were discarded. 3. All dietary staff was in-serviced on	

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F 371	Continued From page 65 07/12/17 from 12:26 PM until 12:30 PM revealed meal carts were taken through the back door of the kitchen to resident hallways. On 07/12/17 at 12:30 PM a fly was observed on the food preparation table next to an open bag of sliced bread and a block of cheese slices. Observations on 07/12/17 at 12:36 PM revealed a fly was on the plastic wrap that partially covered the mozzarella cheese. Continuous observations on 07/12/17 from 12:36 PM until 12:53 PM revealed meal carts were taken through the back door of the kitchen to resident hallways. On 07/12/17 at 12:55 PM the Food Service Director and District Dietary Manager were informed by the surveyor of the fly on the food preparation table next to the opened container of bread and cheese and of the fly on the plastic wrap of the mozzarella cheese and they began to cover opened food items. During an observation on 07/12/17 at 12:56 PM in the service hallway at the back door of the kitchen revealed there was no fly lights or fly fans to repel flies. During an observation on 07/12/17 at 12:58 PM revealed there was 1 fly light above the back door on the service hall that led out to a parking lot and the dumpsters. During an observation on 07/12/17 at 1:05 PM in the main dining room at the door which opened into the kitchen revealed there were no fly lights or fly fans to repel flies. On 07/14/17 at 9:30 AM Cook #1 was not available for interview.	F 371	proper food storage. Completed date 7/31/2007 4. The dietary staff will monitor for proper food storage 3 times per day during meal service for 2 weeks , then 1 time per day during meal service for 2 weeks , then 3 times a week during meal service for 4 weeks, then 1 time a week during meal service for 4 weeks. The dietary manager will report the results at QA for 3 months.	

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During an interview on 07/14/17 at 9:31 AM with Dietary Aide #1 she confirmed she was also the Cook when Cook #1 was off duty. She explained she had seen the flies in the kitchen on 07/12/17 but had not noticed they had been a problem prior to that. She further explained they had received a food delivery on 07/12/17 before lunch through the back door on the service hallway and thought that may have contributed to the flies in the kitchen during the lunch meal service.

During an interview on 07/14/17 at 9:38 AM with the Food Service Director she explained she had noticed flies in the kitchen when the door of the main dining room and the back door at the service hallway were opened. She stated she had only recently been hired by the facility and had noticed there was only 1 fly light at the back door on the service hallway. She explained on 07/12/17 they had received a food delivery that was delivered later than usual and was right before lunch. She further explained the delivery was brought in through the back door onto the service hallway and through the back door of the kitchen and felt the flies probably came into the kitchen during the food delivery. She also confirmed the laundry was across the hall from the back door of the kitchen and staff went in and out the back door of the service hallway frequently. She stated she had recently seen an increase of flies in the kitchen due to the hot and humid weather.

During an interview on 07/14/17 at 9:45 AM with the District Food Service Manager she confirmed she had seen the fly at the food preparation table behind the steam table in the kitchen during the lunch meal service on 07/12/17. She stated she had noticed flies in the kitchen on occasion but it

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was her expectation for flies to be kept out of the kitchen and off open food, food preparation surfaces or on containers of food in the kitchen.

During an interview on 07/14/17 at 10:03 AM, the Administrator stated she had only worked in the facility for 2 weeks. She stated it was her expectation for dietary staff to keep flies off food preparation surfaces and away from open containers of food. She explained she had just started the process to purchase fly lights and blowers to repel flies in the facility but the corporate office would have to approve the request.

During an interview on 07/14/17 at 10:40 AM, the Director of Maintenance confirmed there was currently only 1 fly light located on the service hall by the back door. He confirmed he had just received a request from the Food Service Director for fly lights for the main dining room door to the kitchen and the back door of the kitchen.

2. During an observation on 07/09/17 at 10:38 AM in the nourishment room next to the 700 hallway there were 2 small cartons of whole milk on a shelf inside the refrigerator door that had been opened. A manufacturer's date of 07/09/17 was stamped on the carton but there was no date written on the carton when they had been opened.

During an observation on 07/09/17 at 10:47 AM in the nourishment room next to the 700 hall there were 2 small cartons of whole milk on a shelf inside the refrigerator door that had been opened. A manufacturer's date of 07/09/17 was stamped on the carton but there was no date written on the

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carton when they had been opened.

During an observation on 07/09/17 at 1:57 PM in the nourishment room next to the 700 hallway there were 2 small cartons of whole milk on a shelf inside the refrigerator door that had been opened. A manufacturer's date of 07/09/17 was stamped on the carton but there was no date written on the carton when they had been opened.

During an observation on 07/10/17 at 8:15 AM in the nourishment room next to the 700 hallway there was 1 small carton of whole milk on a shelf inside the refrigerator door that had been opened. A manufacturer's date of 07/09/17 was stamped on the carton but there was no date written on the carton when it had been opened.

During an interview on 07/14/17 at 9:39 AM with the Food Service Director she confirmed the dietary staff supplied milk to the nourishment room next to the 700 hall and was available for resident use. She further stated it was her expectation that milk should be discarded after it was opened.

During an interview on 07/14/17 at 9:45 AM with the District Food Service Manager she stated dietary staff were expected to check nourishment rooms twice a day and should discard any containers of milk that were open. She explained they had a staff member call out on 07/09/17 and that may have been the reason the milk was overlooked and not discarded.

During an interview on 07/14/17 at 10:03 AM with the Administrator she stated it was her expectation milk cartons should be discarded

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F 371	Continued From page 69 after they were opened. 3. During an observation on 07/09/17 at 10:23 AM in the kitchen in the walk in freezer there were 3 cartons of ice cream lying on the floor under metal shelving. During an interview on 07/14/17 at 9:40 AM with the Food Service Director she stated there should be no cartons of food which included ice cream on the floor of the walk in freezer. She stated she expected for staff to pick up any ice cream cartons they saw on the floor of the freezer and to discard them. During an interview on 07/14/17 at 9:45 AM with the District Food Service Manager she stated there should be no ice cream cartons on the floor of the walk in freezer. She stated she expected for staff to look under the shelves and discard any cartons of food they saw on the floor. She explained she had looked in the walk in freezer on 07/07/17 and found ice cream cartons on the floor of the walk in freezer and had discarded them. She further explained she expected for staff to take responsibility for looking on the floor of the freezer and to discard any items they saw. During an interview on 07/14/17 at 10:03 AM with the Administrator she stated it was her expectation there should be no containers of food on the floor in the walk in freezer or in any other food storage area.	F 371		
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain	F 431		8/19/17

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them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(g) Labeling of Drugs and Biologicals.
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

(h) Storage of Drugs and Biologicals.
(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

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F 431	Continued From page 71 (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to keep medications in the original packaging for 6 of 6 medications cart (100 cart, 200 cart, 300 cart, 400 cart, 500/600 cart and 700 cart) that were noted to have loose pills in the drawers, and failed to discard expired/undated insulin on of 2 of 6 medication carts (100 cart and 400 cart). The findings included: 1a. An observation of the 100 medication cart was made on 07/14/17 at 12:45 PM. There was a vial of opened Lantus insulin that was in the top drawer of the medication cart and was available for use that contained no date of when it had been opened. The expiration date had been hand written and stated it expired on 07/13/17. There were also 4 loose pills (1 brown pill, 1 white pill, ½ pink pill, and 1 blue/white capsule) that were present in the top drawer of the medication cart. An interview was conducted with Nurse #2 on 07/14/17 at 12:45 PM. Nurse #2 stated she was responsible for the 100 medication cart. She added she had no idea when the Lantus vial had been opened and confirmed that it expired on	F 431	1. (a) 100 medication cart – Lantus vial was immediately removed and discarded. Loose pills were removed and discarded. (b) 200 medication cart - Loose pill was immediately removed and discarded. (c) 300 medication cart – Loose pill was immediately removed and discarded. (d) 400 medication cart – Novolog pen was immediately removed and discarded. Loose pills were immediately removed and discarded. (e) 500/600 medication cart – Loose pills were removed and discarded. (f) 700 medication cart – Loose pill was removed and discarded. 2. 100% audit of all medication carts were completed by 8/8/17 to ensure all opened medications that require a date were dated. No loose pills were noted. 3. All nurses will be re-educated on labeling medication when opened and discarding loose medications. 4. Director of Nursing and/or designee	

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F 431	Continued From page 72 07/13/17 and should not be on the medication cart available for use. Nurse #2 also stated she had no idea what the loose pills were and she would dispose of them. She added she was not sure what to do with the expired Lantus vial but she would ask her supervisor. Nurse #2 stated that the medication cart was so crowded it was very difficult to get medication in/out of the cart. Nurse #2 stated that she had not checked her cart for expired medication but that the managers had gone through the cart on 07/13/17. She also added she had not noticed the loose pills. b. An observation of 200 medication was made on 07/14/17 at 1:12 PM. There was a loose ½ pink pill in the top drawer of the medication cart. An interview was conducted with Nurse #5 on 07/14/17 at 1:12 PM. Nurse #5 confirmed she was responsible for the 200 medication cart. Nurse #5 stated she had no idea what the loose pill was and she would discard it. Nurse #5 stated she had not noticed the loose pill. c. An observation of 300 medication cart was made on 07/14/17 at 2:44 PM. There was 1 loose beige oblong pill noted in the top drawer of the medication cart. An interview was conducted with Nurse #6 on 07/14/17 at 2:44 PM. Nurse #6 confirmed she was responsible for the 300 medication cart. Nurse #6 stated she did not know what the loose pill was but it should just be thrown away and not kept loose in the medication cart. Nurse #6 stated she had not noticed the loose pill in the cart. d. An observation of 400 medication cart was made on 07/14/17 at 3:03 PM. There was a	F 431	nurses will perform daily cart audits daily, 4 times week x 4 weeks, then 2 times a week for 2 weeks, then 1 time a week for 1 month.. Director of Nursing or Assistant Director of Nursing to do random weekly checks thereafter to ensure compliance. All results will be brought to QAPI x 3 months, or until no further issues noted.	

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Novolog pen that contained no name, no date when it had been opened, and no expiration date. There was also 1 loose round white pill and 2 loose oblong peach pills located in the top drawer of the medication cart.

An interview was conducted with Nurse #5 on 07/14/17 at 3:03 PM. Nurse #5 confirmed she was responsible for the 400 medication carts. Nurse #5 stated she had no idea what the loose pills were and she would discard them. She added that the Novolog pen contained no name, date or expiration date and she stated she had no way of knowing when it expired. Nurse #5 stated she thought the name and date were on the pen this morning when she had used the pen but she could not locate the information now. Nurse #5 stated that she had not gone through the cart and she "could only do what she could do."

e. An observation of 500/600 medication cart was made on 07/14/17 at 3:20 PM. There were 5 (1 round green pill, ½ pink pill, 2 round beige pill, and 1 round orange pill) loose pills located in the 2nd drawer of the medication cart.

An interview was conducted with Nurse #7 on 07/14/17 at 3:20 PM. Nurse #7 confirmed she was responsible for the 500/600 medication cart. Nurse #7 stated she was not sure what the loose pills were and she would find out what she should do with the loose pills.

f. An observation of 700 medication cart was made on 07/14/17 at 3:45 PM. There was 1 loose round white pill located in the top drawer of the medication cart.

An interview was conducted with Nurse #7 on

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F 431	Continued From page 74 07/14/17 at 3:45 PM. Nurse #7 confirmed she was responsible for the 700 medication cart. Nurse #7 stated she was not sure what the loose pill was and she would find out what she should do with the loose pills. The Assistant Director of Nursing (ADON) was unavailable for interview on 07/14/17 at 3:50 PM. The Director of Nursing (DON) was unavailable for interview on 07/14/17 at 3:50 PM. An interview was conducted with the District Director of Clinical Services (DDCS) on 07/14/17 at 3:53 PM. She expected all insulin vials/pens to be dated when opened and discard on or by the expiration date. She added that the medication carts should have no loose pills. If pills became loose they should be discarded. The DDCS added that that pharmacy also inspected the medication carts but was unsure when they were last in the facility.	F 431		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 441		8/19/17

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accepted national standards (facility assessment implementation is Phase 2);

(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

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F 441	Continued From page 76 (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to follow isolation precautions by not donning appropriate personal protection equipment (PPE) for 1 of 1 residents (Resident #99) on droplet precautions. The findings included: Review of the facility's policy for droplet precautions, dated 2012, revealed droplet precautions should be used in addition to standard precautions for residents with infections that can be transmitted by droplets. The policy specified; "A mask should be worn when entering the resident's room or cubicle." It also stated that droplet precautions may be considered for residents with influenza, mycoplasma pneumonia, strep pharyngitis or pneumonia. Resident #99 was admitted to the facility on 07/19/16 with diagnoses which included; persistent vegetative state, resistance to multiple antibiotics, attention to tracheostomy, hypertension, acute and chronic respiratory failure and a highly contagious mucopurulent chronic bronchitis.	F 441	1. Facility ensured proper isolation signage posted to door of room for resident #99 and that proper isolation equipment readily available outside doorway. Nurse #4 re-educated regarding proper donning of PPE prior to entry in room of resident #99. 2. All residents have the potential to be affected by alleged deficient practice. All staff to properly donn and remove PPE when entering or leaving a resident's room who has been placed on precautions as specified in the facility's policy and procedure manual. 3. All staff, to include nursing, housekeeping, therapy, office staff and dietary, will be re-educated on isolation procedures and proper donning of PPE as indicated by facility policy by 8/19/17 by DON/ADON/Nurse Manager (Unit Coordinator, Unit manager) 4. Director of Nursing, Assistant Director of Nursing or designee will complete audits with staff on residents requiring isolation precautions and PPE 4 times a week for 4 weeks, then 2 times a week for	

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F 441	Continued From page 77 Observations on 07/10/17 at 11:14 AM revealed signage posted at the doorway to Resident #99's room which contained the following instructions; Resident was on droplet precautions with masks and gloves to be worn when entering the room. While entering the room, the Director of Nursing (DON) revealed although the signage did not require gowns to be worn she expected gowns to be worn when anyone entered the room. Observation on 07/10/17 at 3:57 PM revealed Resident #99 was in his room and Nurse #4 entered the resident's room without covering her face with a mask, without putting on a gown or putting on gloves on hands per the droplet precaution instructions posted at the doorway to the resident's room. After entering the resident's room Nurse #4 was observed to walk to the far side of the room and place a urinal on a brown rolling tray table and exit the room. At the time Nurse #4 exited the resident's room, the Director of Nursing (DON) was standing at the door to the resident's room. When Nurse #4 exited the resident's room the DON asked her what she was doing. Nurse #4 responded "What? I didn't touch nothing." During an interview with the Assistant Director of Nursing (ADON), who was also the facility's infection control nurse, on 07/12/17 at 2:57 PM, she stated Resident #99 was on droplet precautions due to the current treatment of a multi-drug resistant pneumonia. She specified Resident #99 was isolated for droplet precautions upon readmission to the facility from a hospitalization in May of 2017. Review of resident's physician orders revealed no physician order for isolation/droplet precautions. When	F 441	2 weeks, and then 1 time a week for 1 month. Data obtained during this audit process will be analyzed for patterns and trends and reported to Quality Assurance (QAPI) by Nurse Manager for 3 months at which time the committee will evaluate the effectiveness of the interventions and determine if further auditing is necessary to sustain ongoing compliance.	

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F 441	Continued From page 78 asked about the lack of a physician's order, she stated per her Statewide Program for Infection Control and Epidemiology (SPICE) training and guidelines, there did not have to be an explicit order for isolation precautions. When asked what her expectation of was of staff entering Resident #99's room in regards to PPE, she stated it was her expectation that PPE was to be worn when providing care or entering the room and coming within 6-10 feet of the Resident #99.	F 441		
F 469 SS=B	483.90(i)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM (i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility failed to ensure that fly reduction measures were effective to prevent fly activity for 3 of 3 residents (Resident #24, Resident #122, and Resident #124). The findings included: 1a. Resident #24 was admitted to facility on 11/21/13 with diagnoses that included: hypertension, diabetes mellitus, and peripheral vascular disease. Review of the most recent quarterly minimum data set (MDS) dated 06/02/17 revealed that Resident #24 was cognitively intact. An observation and interview was conducted with Resident #24 on 07/12/17 at 11:51 AM. There was a fly buzzing around Resident #24 who was sitting beside her bed in her room. Resident #24	F 469	1. Maintenance Director notified facility Pest Management Company of immediate need for services. 2. Maintenance Director and pest control completed a round in the facility to determine the most effective way to manage the alleged deficient practice. 3. Administrator/DON or designee will re-educate department heads as well as Licensed and unlicensed staff regarding the observation for pest control. Maintenance Director ordered Fly lights for the facility. Halo Fly lights were installed by the Maintenance Director 7/28/17. 4. Maintenance Director and Ambassadors (department heads) will round the facility and report any pest control issue immediately to the Maintenance Director and or the Administrator. Audits by the Maintenance	8/19/17

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F 469	Continued From page 79 grabbed a fly swatter that was hanging on her dresser and stated "if I catch em I kill em." Resident #24 stated that she keeps her fly swatter close by because the flies seem to "like her room." An observation of Resident #24's room was made on 07/13/17 at 4:28 PM. There was fly that was buzzing around Resident #24's bed. b. Resident #122 was admitted to the facility on 01/02/17 with diagnoses that included: neurogenic bladder, non-Alzheimer's dementia. Review of the most recent quarterly minimum data set (MDS) dated 07/02/17 revealed that Resident #122 was cognitively intact. An observation and interview with Resident #122 was conducted on 07/11/17 at 8:53 AM. Resident #122 was up in his wheelchair with his breakfast tray in front of him. There was 2 flies buzzing around him and the breakfast tray. Resident #122 stated "they seem to stay in my room all the time." An observation of Resident #122's room was made on 07/14/17 at 9:07 AM. Resident #122 was up in his wheelchair with his breakfast tray in front of him. Resident #122 was observed to be swatting a fly that buzzing around him and the breakfast tray. c. Resident #153 was admitted to the facility on 06/30/17 with diagnoses that included: cancer, hypertension, end stage renal disease. Review of the most recent comprehensive minimum data set (MDS) dated 07/11/17 that	F 469	Director and Ambassadors will occur 5 days week ongoing. Data obtained during the audit process will be brought to Quality Assurance (QAPI) to be reported for 3 months.	

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Resident #155 was mildly cognitively impaired.

An observation of Resident #153's room was made on 07/10/17 at 3:23 PM Resident #153 was observed to be swatting a fly that was buzzing around her hands and bedside table.

An observation of Resident #153's room was made on 07/13/17 at 10:03 AM. Resident #153 was noted to be resting in bed with her eyes closed and her mouth open. There was a fly buzzing around her head/neck.

An interview was conducted with the Director of Maintenance (DOM) on 07/12/17 at 4:22 PM. The DOM stated he had not seen an increase in flies this week. He added that the facility had a contract with a local exterminating company and they came to the facility once a month and treated for pest/insects including flies. The DOM stated that to his knowledge to no one had complained of flies. He added that the facility had one fly light located on the service hall of the facility. The DOM stated that the facility had no fly fans or fly traps that he was aware of.

Review of a "Chemical Use Log" from the contract exterminator dated 07/13/17 read in part, the facility had been treated for flies. The Noted recommendations were: spoke to the DOM about adding 7 new fly lights to the facility.

An interview was conducted with the Administrator on 07/14/17 at 10:20 AM. The Administrator stated she had noticed the flies and stated, "they are all over." She added that she had ordered 7 fly lights for the facility and 4 blowers that would be installed on the entry/exit doors at the facility after the extermination

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F 469	Continued From page 81 company had made the recommendations on 07/13/17. The Administrator added she had identified that flies were a big problem in the 2 weeks since she arrived at the facility.	F 469		
F 490 SS=G	483.70 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING 483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, family, and staff interviews the facility's administration failed to manage the care and needs of residents in the building for 4 of 6 residents sampled (Resident #93, #29, #147, and #69). The findings included: 1. Cross Reference F-166: Based on record review and staff interviews the facility failed to ensure the grievance investigations and resolutions were provided in writing to 3 of 3 sampled residents and/or their responsible parties (Residents #93, #29 and #147). 2. Cross Reference F-224: Based on observation, record reviews, staff and family interviews the facility neglected to assess and provide treatment for pressure ulcer and neglected to clean and trim a dependent	F 490	Resident # 93, Resident # 29, and Resident # 147 are no longer residing in facility. All concerns in the last 30 days related to current residents will be reviewed and written resolutions will be presented to each person voicing said concern. Education will be provided to all department managers by the Administrator regarding resolution of concerns and follow-up expectations, inclusive of written resolutions being provided. Five grievances per week will be reviewed by the Administrator or designee 5 x weekly to ensure written resolutions have been provided by the department head as assigned by the Administrator. Results will be brought to QAPI x 3 months, or until no further issues noted. Resident #69□s nails were trimmed by NA	8/19/17

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F 490	Continued From page 82 residents finger nails for 1 of 3 residents (Resident # 69). The facility neglected to assess and seek treatment for Resident #69 which resulted in a decline of the pressure ulcer condition from redness upon admission on 06/15/17 to black necrotic tissues on 06/25/17. 3. Cross Reference F-353: Based on observations, record reviews, family, significant other, and staff interviews the facility failed to have sufficient quantity of staff to ensure a dependent resident was provided pressure ulcer care, nail care, and apply splint as ordered to prevent further contractures (Resident #69) for 1 of 4 sampled residents. The Director of Nursing (DON) was unavailable for interview on 07/14/17 at 10:00 AM. An interview was conducted with the Administrator on 07/14/17 at 2:37 PM. The Administrator stated that she had only been at the facility for 2 weeks and was still trying to figure out all the processes in the facility. She added that she had not even had time to read the reports from the prior survey and honestly she had no idea if the facility was at a point to stop their monitoring tools or not. She added that she had not yet been trained on all the polices and was not even sure how or where to pull the facilities policies.	F 490	on 7/14/17. Pressure ulcer treatment initiated for resident #69 on 6/25/7. All residents with pressure areas have the potential to be affected by the alleged deficient practice. Administrative RN (DON,ADON,Nurse Manager, Unit Coordinator) completed an audit of all residents with pressure areas on 8/4/17 to ensure treatment initiated and Practitioner notification occurred. No areas of concern noted. All dependent residents (residents with an ADL score of 10 or greater) have the potential to be affected by the alleged deficient practice. Administrative RN (DON,ADON,Nurse Manager, Unit Coordinator) completed an audit of all dependent resident□s finger nails to ensure nails were trimmed and clean on 7/14/17. No areas of concern noted. Nursing staff will be educated by DON/ADON by 8/19/17 regarding initiating treatment for pressure ulcers and practitioner notification of pressure ulcer; including noting changes in ulcer. Any staff that have not completed the education will not work until education is completed. Certified Nursing assistants will be re-educated by DON/ADON by 8/19/17 regarding ADL care to include trimming and cleanliness of resident finger nails. All nursing staff will be re-educated regarding resident neglect in relation to ADL care and treatment of pressure ulcers.. Administrative RN (DON,ADON,Nurse Manage,Unit Coordinator) or designee will audit all residents with pressure ulcers for changes, notification and active treatment	

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F 490	Continued From page 83	F 490	4 times a week for 4 weeks, then 2 times a week for 2 weeks, and then 1 time a week for 1 month. Administrative staff or designee will audit dependent residents (residents with an ADL score of 10 or greater) to ensure lengthy fingernails are trimmed and nails are clean 3 times a week for 4 weeks then 2 times a week for 2 weeks and then weekly for 1 months. Administrator/DON and/or designee will review staffing needs daily in IDT meeting. Data obtained during the audit process will be analyzed for patterns and trends and reported to the QAPI committee by the Adminstrative RN (DON,ADON,Unit Manager,Unit Coordinator) or designee for 3 months at which time the committee will evaluate the effectiveness of the interventions and determine if further auditing is needed.	
F 514 SS=E	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 514		8/19/17

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F 514	Continued From page 84 (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 reviews and staff interviews the facility failed to document functionality of a bed alarm for a resident at risk for falls (Resident #93), failed to document the correct location of redness or measurements on a resident's heel or whether drainage was present (Resident #69) and failed to document falls for a resident at risk for falls (Resident #122) for 3 of 6 sampled residents for falls and pressure ulcers. Findings included. 1. Resident #93 was admitted to the facility on 06/07/17 with diagnoses which included congestive heart failure, muscle weakness, diabetes and chronic obstructive lung disease. A review of the admission Minimum Data Set (MDS) dated 06/15/17 revealed Resident #93 had	F 514	1. Resident # 93 no longer resides at facility. Resident # 69 - wound was assessed and documented on 6/25/2017 Resident # 122 fall interventions updated and are reflective on care plan and Kardx. 2. Audit of current residents having orders for bed alarms completed to include documentation of functionality. Audit ensuring current residents with wounds have proper documentation. Audit of all falls for the last 30 days have proper documentation. 3. Education provided to nursing staff with the expectation functionality of alarms is to be documented every day. Education provided to nursing staff that residents admitted/readmitted to facility	

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F 514	Continued From page 85 short term and long term memory problems and was severely impaired in cognition for daily decision making. The MDS further revealed Resident #93 required limited assistance with locomotion but required extensive assistance with bed mobility and transfers. A review of an incident/accident report dated 06/13/17 at 4:00 PM revealed Resident #93 was found sitting on the floor on the right side of his bed. The report indicated there was no injury and a section labeled actions indicated to add pressure pad to the bed. A review of a physician's order dated 06/14/17 revealed bed alarm pad. A review of a care plan dated 06/29/17 indicated Resident #93 was at risk for falls related to a stroke with weakness, a history or falls and medications received. The goal revealed Resident #93 would be free of falls and the interventions were listed in part for a pressure alarm to his bed. A review of a Treatment Administration Record (TAR) dated 06/14/17 through 06/30/17 indicated bed alarm pad but there were no nurse's initials documented. During an interview on 07/12/17 at 6:31 PM with Nurse #1 she stated she was a Unit Manager and provide supervision to nursing staff. She confirmed Resident #93 had a fall and after he fell physical therapy assessed him and a bed alarm was ordered for his bed. During an interview on 07/14/17 at 3:15 PM with Nurse #3 she stated she was a Unit Coordinator	F 514	are to have skin assessments completed and documented within 24 hours. Education provided to nursing staff to ensure documentation in resident's record following a fall. 4. Director of Nursing and/or designee will audit 3 residents 4 x weekly x 4 weeks, then 2 x weekly x 2 weeks, then 1 time a week for 1 month, and then randomly during clinical meeting for documentation of functionality of alarms, skin assessments are completed and documented on within 24 hours and to ensure proper documentation in resident's record following a fall. Findings will be reported to QAPI for 3 months with adjustments made to plan as necessary.	

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and confirmed Resident #93 had a bed alarm in place on his bed because she had heard it alarm at times. She explained documentation of the functionality of bed alarms was supposed to be done on the resident's TAR. She further explained when a resident had a bed alarm ordered the order was transcribed to the TAR and the nurse was supposed to document their initials on the TAR when the alarm was checked to make sure it was functioning properly. After review of Resident #93's TAR she confirmed there was no documentation of the functionality of the alarm on the TAR. She then looked into the computer system at Resident #93's TAR and stated whoever entered the order did not select the scheduling button to indicate when to check the alarm. She explained since there were no scheduling details selected there was no documentation of the functionality of the bed alarm.

During an interview on 07/14/17 at 3:23 PM with the District Director of Clinical Services (DDCS) with the Administrator present she reviewed the TAR for Resident #93 and confirmed there was no nursing documentation of the functionality of the alarm. She stated it was her expectation for nursing documentation to include whether the alarm was functioning and working properly and in the proper place.

During an interview on 07/14/17 at 3:30 PM with the Administrator she stated her expectations were the same as the DDCS.

2. Resident #69 readmitted to the facility with diagnosis that included: recent aspiration pneumonia, previous stroke with residual hemiplegia, and peripheral vascular disease. The

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Minimum Data Set quarterly assessment dated 06/22/17 indicated that resident #69 was severely impaired cognitively. The resident also required extensive assistance for bed mobility/positioning and transfers from bed. He was dependent on staff for all personal care. The resident received nutrition through a feeding tube and was dependent on supplemental oxygen.

Review of skin assessment form dated 06/15/17 revealed resident had an area of reddened skin on right heel. The form was not completed in the area intended for documentation of size, type, and description of the wound.

Review of medical record revealed follow up weekly skin assessment was dated 06/25/17.

Review of MD orders for Resident #69 revealed wound care orders which were initiated on 06/25/17 for an unstageable pressure ulcer on the left heel.

An observation was made of the wound on the left heel of Resident #69 on 07/12/17 at 2:17 PM. The wound on the resident's left heel had pink and greyish tissue and the wound was surrounded by darkened flaky skin.

An interview was conducted with Nurse #2 who stated that she had completed the skin assessment of Resident #69 on date of readmission 06/15/17. Nurse #2 stated that she had marked the form incorrectly. Nurse # 2 stated that the reddened area had been on the left heel of Resident #69. Nurse #2 also stated that she had not documented the description or size of the area on the left heel.

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An interview was conducted with Wound Care Specialist on 07/14/17 at 11:07 AM. The Wound Care Specialist stated that the resident had a Stage III pressure ulcer on his left heel. The Wound Care Specialist stated also that it was her expectation that wounds would be assessed and documented in the medical record.

The Assistant Director of Nursing (ADON) was interviewed on 07/13/17 at 3:51 PM. The ADON stated it was her expectation that a skin assessment would be filled out completely to include description of and measurement of wounds for residents with wounds. The ADON stated it was also her expectation that wounds had follow up assessment completed weekly or whenever the condition of the wound changed.

An interview was conducted with the facility MD on 07/14/17 at 5:53 PM. The MD stated that it was the expectation that wounds be assessed and MD be notified of wounds.

3. Resident #122 admitted to the facility on 01/02/17 with diagnoses that included quadriplegia, anxiety, dementia, insomnia, glaucoma, and others.

Review of the most recent quarterly minimum data set (MDS) dated 07/02/17 revealed that Resident #122 was cognitively intact and required extensive assistance of 1 to 2 staff members for activities of daily living. The MDS further revealed that Resident #122 had 2 or more falls with injury since the prior assessment.

The facility provided incident reports for Resident #122 which indicated Resident #122 had fallen 3 times. The falls occurred on the following days:

- 04/03/17

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F 514	Continued From page 89 - 05/11/17 - 05/17/17 Review of the medical record revealed no documentation in a nurse's note or Situation, Background, Assessment, Recommendation (SBAR- type of communication tool) of the fall that occurred on 04/03/17. Review of the daily assignment sheet for 04/03/17 revealed that Nurse #8 was responsible for Resident #122 at the time of his fall. An interview with the Assistant Director of Nursing (ADON) was conducted on 07/13/17 at 2:01 PM revealed that all falls were supposed to be documented in the medical record either as a nurse's note or a SBAR. Attempts to reach Nurse #8 on 07/13/16 at 4:33 PM were unsuccessful. The Director of Nursing (DON) was unavailable for interview on 07/14/17 at 10:00 AM. An interview was conducted with the Administrator on 07/14/17 at 10:53 AM. The Administrator stated that she expected all falls to be documented in the medical record and all records to be as accurate as possible. An interview was conducted with the District Director of Clinical Services (DDCS) on 07/14/17 at 4:05 PM. The DCS stated that she expected all medical records to be complete and accurate. An interview was conducted with Nurse #1 on 07/14/17 at 4:43 PM. Nurse #1 confirmed that she had completed the incident report on	F 514		

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F 514	Continued From page 90 04/03/17 when Resident #122 fell. She stated that she was the supervisor that weekend and just happened to be walking by his room and saw that Resident #122 had fallen. Nurse #1 stated that she was still very new to the facility and she had not documented in the medical record, she stated she could have documented but since she was so new she had not. She added that the nurse on the hall was ultimately responsible for the documentation. Nurse #1 could not recall which nurse was on the hall on 04/03/17.	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; (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	F 520		8/19/17

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F 520	Continued From page 91 (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in November 2016 following a recertification and complaint survey and subsequently recited in July 2017 on the current recertification and complaint survey. The repeat deficiencies are in the areas of notification (F157), environment (F253), activities of daily living (F312), store/prepare/serve food under sanitary conditions (F371), and medication storage (F431). These deficiencies were recited during the facility's current recertification and complaint survey. The continued failure of the facility during 2 federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included:	F 520	1. Facility Administrator conducted a Quality Assurance and Improvement Committee meeting on 8/8/2017 to discuss the recitation of tags F253, F312, F371 and F431. 2. All residents residing in the facility have the potential to be affected. 3. Facility Administrator and Divisional Director of Clinical Services reeducated the Interdisciplinary team and members of the Quality Assurance and Improvement Committee by 8/8/17 regarding accurately reporting and revising current action plans as well as developing and implementing a new action plans to assure state and federal compliance in the facility. Any Interdisciplinary Team member that has not received the Quality Assurance and Improvement education prior to 8/8/17 will be unable to work until he/she has received the Quality Assurance and Improvement education.	

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F 520	Continued From page 92 1a. This tag is cross referred to: F-157; Based on record reviews, staff interviews, nurse practitioner and Medical Doctor (MD) interviews, the facility failed to notify the nurse practitioner and the physician of development of pressure ulcer in 1 of 4 sampled residents. (Resident #69). During the recertification and complaint survey of 11/03/16, this regulation was cited for failing to notify the physician of a residents eye enucleation (removal of the eye) that began draining purulent drainage for 1 of 2 sampled residents (Resident #25) and failed to notify the physician of a blood sugar that exceeded the ordered parameters for 1 of 2 sampled residents (Resident #38). During the current recertification and complaint survey this regulation was cited for failing to notify the physician of a pressure ulcer. 1b. This is a cross refer to: F-253; Based on observations and staff interviews the facility failed to repair broken and splintered laminate on resident room doors and a bathroom door on 4 of 12 resident rooms and 1 of 1 common bathroom door (Rooms 205, 401, 408 and bathroom on the 300 hall), failed to repair broken floor tile in 1 of 12 resident rooms (room 100), failed to repair patches on walls in 4 of 12 resident rooms (room 200, 202, 206, and 404) and failed to repair water damage on the ceiling in 1 of 12 resident rooms (room 104). During the recertification and complaint survey of 11/03/16, the regulation was cited for failing to label a urinal and a fracture bed pan in 2 resident	F 520	4. The Interdisciplinary Team including the facility Medical Director will meet monthly on the third Tuesday of each month to conduct the facility's Quality Assurance and Performance Improvement meeting. Special attention will be given to assessing the effectiveness of the monitoring of repeat deficiencies F253, F312, F371, and F431 as well as the prevention of any new repeat deficiencies Should any interdisciplinary team member find that the facility may need an Impromptu Quality Assurance and Performance Improvement meeting for a facility compliance issue, the Administrator will organize a meeting and notify all team members in order for a revision to any present action plan or for a need for a new action plan in order to maintain compliance in the facility. Quality assurance monitoring will take place at each Quality Assurance and Performance Improvement meeting monthly and any impromptu meetings held. This monitoring tool will be signed off by each Interdisciplinary team member after each meeting accepting and acknowledging all monitoring and revisions set forth by the Quality Assurance and Performance Improvement committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND RETIREMENT	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 93	F 520		

bathrooms (Room #106 and #310) on 2 of 7 resident hallways, failed to repair 13 resident doors (Resident Room #103, #201, #205, #207, #305, #310, #311, #401, #405, #512, #601, #700 and #706) with broken and splintered laminate and wood on the edges of the bottom half of the doors (100, 200, 300, 400, 500, 600 and 700 halls), failed to repair 1 of 2 doors to the recreation room with broken and splintered laminate on the lower edges of the door (100 hallway), failed to repair a set of smoke prevention doors (700 hall) with broken and splintered laminate on the lower edges of the doors on 1 of 7 hallways and failed to repair a wall behind a resident's bed with deep gouges into the sheet rock (Room #410-A) on 1 of 7 resident hallways.

During the current recertification and complaint survey this regulation was cited for failing to repair broken and splintered laminate on resident room doors and a bathroom door on 4 of 12 resident rooms and 1 of 1 common bathroom door (Rooms 205, 401, 408 and bathroom on the 300 hall), failed to repair broken floor tile in 1 of 12 resident rooms (room 100), failed to repair patches on walls in 4 of 12 resident rooms (room 200, 202, 206, and 404) and failed to repair water damage on the ceiling in 1 of 12 resident rooms (room 104).

1c. This is a cross refer to F-312;

Based on observations, record review, family, and staff interviews the facility failed to trim and clean a dependent residents fingernails for 1 of 5 residents sampled for activities of daily living (Resident # 69).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 07/14/2017

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 94 During the recertification and complaint survey of 11/03/16 this regulation was cited for failing to trim a dependent residents fingernails for 1 of 3 residents sampled for activities of daily living (Resident #97). During the current recertification and complaint survey this regulation was cited for failed to trim and clean a dependent residents fingernails. 1d. This is a cross refer to F-371; Based on observations and staff interviews the facility failed to keep flies out of the kitchen area during food production and meal service, failed to discard opened containers of milk that were not dated when opened and failed to remove 3 cartons of ice cream from the floor of the walk in freezer. During the recertification and complaint survey of 11/03/16 this regulation was cited for failing to clean a fan that contained gray debris hanging from the metal grates on the front and back of the fan that was in use and located in a food preparation area next to clean pots and pans and the facility failed to clean a dirty microwave located in 1 of 2 nourishment rooms (700 hall). During the current recertification and complaint survey this regulation was cited for failing to keep flies out of the kitchen area during food production and meal service, failing to discard open containers of milk that were not dated when opened and failing to remove 3 cartons of ice cream off the floor of the walk in freezer. 1e. This is a cross refer to F-431;	F 520		

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	345179	A. BUILDING _____ B. WING _____	C 07/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND RETIREMENT	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 95 Based on observations, record review, and staff interviews the facility failed to keep medications securely in the original packaging for 6 of 6 medications cart (100 cart, 200 cart, 300 cart, 400 cart, 500/600 cart and 700 cart) that were noted to have loose pills in the drawers and failed to discard expired/undated insulin on of 2 of 6 medication carts (100 cart and 400 cart). During the recertification survey and complaint survey of 11/03/16 this regulation was cited for failing to remove expired medications from 1 of 4 medication carts. During the current recertification and complaint survey this regulation was cited for loose pills in 6 of 6 medication carts and for expired/undated insulin in 2 of 6 medication carts. An interview was conducted with the Administrator on 07/14/17 at 5:18 PM. The Administrator stated she had only been at the facility for 2 weeks and they have had 1 Quality Assurance (QA) meeting since she had been present. She stated that the Director of Nursing (DON) ran the meeting and each department head was present. She further explained that each team member brought their own information to the meeting and present the information to the group. The Administrator stated she had not reviewed the finding from the previous recertification survey and was unaware of the monitoring tools that were and were not being completed. The Administrator stated she was going to go to sister facility soon for training on the company's QA process and would bring that information back to the facility and implement as needed.	F 520		