STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345354	A. BUILDING _____ B. WING _____	C 09/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEY GROVE NURSING AND REHABILITATION CENTER	728 PINEY GROVE ROAD KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS There were no deficiencies cited as a result of the complaint investigation of 9/15/17. Event ID# UB9J11.	F 000		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).	F 272		10/13/17

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

Electronically Signed | 10/09/2017

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F 272	Continued From page 1 (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to conduct a comprehensive dietary assessment for 1 of 4 residents (Resident #68) reviewed for nutrition. Findings included: Resident #68 was admitted to the facility on 9/1/15 with diagnoses which included: Alzheimer's dementia, dysphagia, adult failure to thrive, anorexia, aspiration, and feeding difficulties. The annual Minimum Data Set (MDS) dated 6/20/17 indicated Resident #68 was severely, cognitively impaired; required limited assistance with eating; no swallowing problems; was 58 inches in height; weighed 91 pounds; no weight loss or gain; and received a mechanically altered diet. There was no comprehensive dietary assessment	F 272	Piney Grove Nursing and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Corrections is submitted as a written allegation of compliance. Piney Grove Nursing and Rehabilitation response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute and admission that any deficiency is accurate. Further, Piney Grove Nursing and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal	

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F 272	Continued From page 2 completed for Resident #68. The resident's most recent dietary assessment was a quarterly dated 5/26/17. During an interview on 9/13/17 at 5:02 p.m., the RD revealed that the Dietary Manager (DM) was responsible for completing the dietary supplemental assessments. The RD stated she reviewed Resident #68's clinical record, including weights in June 2017, when the resident was referred to her (RD) due to a significant weight change of 13% weight loss. During a meal observation on 9/14/17 at 12:00 p.m., Resident #68 in the dining room in a wheelchair feeding herself butter pecan, magic cup (nutritional supplement). The resident was observed refusing encouragement from staff to eat some of the pureed meal on her sectioned plate. She also refused to drink any of her whole milk. The resident did consume some of her chocolate pudding and some of her iced tea. On 9/13/17 at 5:12 p.m., the Dietary Manager (DM) stated the reason Resident #68's dietary assessment was last completed on 5/26/17 was due to a shortness of dietary staff resulting in her (DM) working as a cook, dietary aide, and as facility receptionist from 4:00 p.m.-7:00 p.m. The DM revealed the dietary department had been operating with less staff for two months. During an interview on 9/15/17 at 10:15 a.m., MDS Nurse#2 stated Resident #68's dietary assessment should have been completed between 6/14/17 and 6/20/17 (date of the annual MDS). MDS Nurse#2 revealed the DM was to use the completed Dietary Supplemental	F 272	proceeding. F272: Comprehensive Assessments On 10/05/17, a comprehensive dietary assessment for Resident #68 was completed by the Minimum Data Set (MDS) Coordinator. On 10/05/17, a 100% audit of all residents was initiated by the MDS nurse and Director of Nursing (DON) to ensure a comprehensive dietary assessment had been completed. This audit will be completed by 10/13/17. It has been determined that a comprehensive assessment needs to be completed with any MDS that requires section K of the Resident Assessment Instrument (RAI). On 10/05/17, an in- service was completed for the MDS nurse by the corporate consultant and DON regarding completing comprehensive dietary assessments with the section K of the MDS assessment. On 10/8/17, an audit of 25% of residents will be conducted weekly times 4 weeks, then twice weekly for 4 weeks then 10% monthly times 2 months by the DON to ensure compliance and completion of comprehensive dietary assessments. All Identified areas of concern will be addressed immediately by the DON through retraining to the MDS nurse. Corrections will be made as identified.	

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F 272	Continued From page 3 (Assessment) sheet to complete section K of the MDS.	F 272	The results of the audits will be presented by the administrator and/or DON the monthly QI meeting for recommendations.	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews the facility failed to complete a comprehensive assessment after a resident (Resident #37) experienced changes in two areas, acquired pressure ulcer and unplanned weight loss. The findings included: Resident #37 was admitted to the facility on 4/11/13 with diagnoses of dementia and diabetes. Record review revealed Resident #37 had significant weight loss from a 2/16/17 weight of 124 pounds to 8/3/17 weight of 111 pounds. This represented a weight loss of 13 pounds or a 10.4% loss in 180 days.	F 274	F274 Comprehensive Assessment after Significant Change On 10/06/17, resident #37 had a comprehensive assessment completed by the Minimum Data Set nurse (MDS) using the Resident Assessment Instrument (RAI). On 10/05/17, the Director of Nursing (DON), MDS nurse, staff facilitator and corporate consultant initiated a 100% audit of resident records to identify if any resident was in need of a comprehensive assessment. No other significant change assessments were needed.	10/13/17

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F 274	Continued From page 4 Review of the dietary assessment dated 8/3/17 revealed Resident #37 was assessed as having a nutritional problem of eating less than 3 meals a day, leaving 25% or more of the food at most meals and eating less than 3 meals a day. The assessment checked that she was on a planned weight loss/gain program and weight loss had for 180 days was not identified. Record review revealed Resident #37 had developed a suspected deep tissue injury pressure ulcer of the right heel and the wound was identified on 8/7/17. The current Minimum Data Set (MDS) dated 7/11/17, a quarterly assessed Resident #37 with no skin issues or pressure ulcers and no weight loss. The care plan dated 8/2/17 included a problem of at risk for impaired skin integrity and weight loss. Observations of the wound on 9/13/17 at 9:39 AM revealed the heel area was dry, yellow with scabbing noted in the center of the wound. Interview with the treatment nurse on 9/13/17 at 9:45 AM revealed the heel was soft, mushy and purplish in color when first noted. Interview with the MDS nurse on 9/13/17 at 10:18 revealed she was not aware Resident #37 had a pressure ulcer or significant weight loss. She explained the treatment nurse usually provided a weekly wound report, but one had not been provided in the month of August. She further explained she did not have communication with the Dietary Manager about weights. Further interview revealed the Dietary Manager was	F 274	On 10/05/17, an in-service was completed, by the corporate consultant, with the MDS nurse, treatment nurse, and DON on completing a comprehensive assessment within 14 days after the facility determines that there has been a significant change in the resident□s physical or mental condition. The DON and/ or staff facilitator will review physician orders and twenty four hour reports in morning meeting to effectively communicate to the interdisciplinary team any changes in resident status. On 10/09/17, an audit of 25% of residents will be conducted weekly times 4 weeks, then every two weeks for 4 weeks then, 10% monthly times 2 months by the DON. This is to ensure compliance and completion of comprehensive assessments after significant changes. All identified areas of concern will be addressed immediately by the DON through retraining to the MDS nurse. Corrections will be made as identified. The results of the audits will be presented by the administrator and/or DON to the monthly Quality Improvement meeting for recommendations.	

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F 274	Continued From page 5 supposed to review weights monthly. The care plan had not been updated. Interview with the MDS nurse on 9/15/17 at 11:14 AM revealed a significant change had not been completed as it did not meet the criteria. She explained her decision was based on the physician ' s note dat3ed 8/14/17 that weight loss would be expected due to her dementia. On 9/15/17 at 11:15 AM an interview was conducted with the Director of Nursing. She explained she was not aware there was a problem with communication between disciplines about changes in condition. i.e. wounds, weights.	F 274		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive	F 279		10/13/17

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F 279	Continued From page 6 care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by:	F 279		

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F 279	Continued From page 7 Based on physician and staff interviews and record review, the facility failed to create a care plan for a resident with a pressure ulcer for 1 of 3 residents (Resident #50) reviewed for pressure ulcers and failed to create a care plan for a resident with weight loss for 1 of 6 residents (Resident #17) reviewed for nutrition. Findings included: 1. Resident #50 was admitted to the facility on 4/19/16. He discharged to the hospital on 5/5/17 and then re-admitted to the facility on 5/12/17. His diagnoses included, in part, diabetes mellitus, cancer, depression and congestive heart failure. Resident #50's Annual Minimum Data Set (MDS) assessment dated 4/4/17 revealed no pressure ulcers but that the resident was at risk of developing pressure ulcers. A review of the Quarterly MDS assessment dated 9/5/17 revealed the resident had one or more unhealed pressure ulcers at stage 1 and had two unstageable pressure ulcers due to suspected deep tissue injury. A review of the Care Area Assessment (CAA) dated 4/5/17 indicated that pressure ulcers would be addressed in the care plan. A review of the CAA findings revealed, "Potential for pressure ulcers related to frequent urinary incontinence, history of pressure ulcer." The CAA further stated, "Resident #50 will not develop a pressure ulcer through next review." A review of the care plan provided by the Administrator on 9/13/17 at 8:53 AM revealed there was no care plan completed in April that addressed pressure ulcers. A care plan provided by MDS Nurse #1 on	F 279	F279 Develop Comprehensive Care Plans Resident #17□s care plan was updated on 10/06/17 by the Minimum Data Set nurse (MDS) to show weight loss and current interventions that are in place. Resident #50□s care plan was updated on 09/13/17 by the MDS nurse, to include weight loss and risk for pressure ulcers. On 10/06/17, the Director of Nursing (DON), MDS nurse, staff facilitator and corporate consultant initiated a 100% audit of resident records to identify if any resident needed to have the care plan updated to include risk for pressure ulcer, actual pressure ulcers, and weight loss. On 10/05/17, the corporate consultant completed an in-service with the MDS nurse, treatment nurse, and DON on updating the care plans with current conditions of the residents. The in-service includes the need to update care plans with weight loss, nutrition, and pressure ulcers. The DON and/ or staff facilitator will review physician orders and twenty four hour reports in morning clinical meeting to effectively communicate with the interdisciplinary team any changes in resident status. On 10/9/17, an audit of 25% of residents will be conducted weekly times 4 weeks, then every two weeks for 4 weeks, then 10% monthly times 2 months by the DON. This is to ensure compliance and completion of comprehensive	

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F 279	Continued From page 8 9/13/17 at 10:17 AM revealed a care plan for pressure ulcers dated 9/13/17. An interview was completed with MDS Nurse #1 on 9/13/17 at 2:17 PM. She reported she re-activated the pressure ulcer care plan after she completed the quarterly assessment and said she was not aware that Resident #50 "had a pressure ulcer until last night." She was unsure when the pressure ulcer was first identified. MDS Nurse #1 said she reviewed the CAA dated 4/5/17 and expected a care plan to have been initiated for pressure ulcers at that time. An interview was completed with MDS Nurse #2 on 9/13/17 at 2:25 PM. She stated she completed CAA's and care plans at the same time and said she must have been interrupted while she completed the pressure ulcer CAA and care plan. "I probably got interrupted, I was acting DON from February-April; it was my oversight." She was unable to locate the pressure ulcer care plan from April that she indicated she would develop based on the CAA. An interview was completed with the Director of Nursing on 9/15/17 at 10:30 AM. She said she expected a care plan to be developed if the CAA indicated to proceed to care plan. 2. Resident #17 admitted to the facility on 7/14/17 with diagnoses that included, in part, malnutrition, depression, and pressure ulcer of unspecified ankle, unstageable. A review of the comprehensive Minimum Data Set (MDS) assessment dated 7/21/17 revealed Resident #17 had moderately impaired cognition and needed supervision with set up assistance	F 279	assessments after significant changes. All identified areas of concern will be addressed immediately by the DON and along with the MDS nurse. Corrections will be made as identified. The results of the audits will be presented by the administrator and/or DON at the monthly Quality Improvement meeting for recommendations.	

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F 279	Continued From page 9	F 279		

for eating. Further review of the MDS revealed Resident #17 was 69 inches tall and weighed 136 pounds.

A review of the care plan revealed no current care plan that addressed nutrition. A review of the Care Area Assessment (CAA) worksheet dated 7/26/17 revealed Resident #17's state of nourishment was poor due to poor oral intake, a supplement was provided twice a day, there was an unstageable wound, the resident ate 0-25% of most meals, needed to be supervised during all meals and received diuretics. Further review of the CAA revealed that nutritional status would not be addressed in the care plan since supplements were provided and there was no weight loss at the time the CAA was completed.

A review of the medical record revealed the weights for Resident #17 were as follows: 7/18/17 weighed 136 pounds, 8/25/17 weighed 124 pounds and 9/11/17 weighed 122 pounds.

An interview was completed with the Certified Dietary Manager (CDM) on 9/14/17 at 9:31 AM. She stated she did not proceed to care plan for nutrition because Resident #17 was admitted with a weight of 136 pounds and even though the resident's nourishment was poor, her intake was poor and she had wounds the CDM did not think a care plan needed to be developed for nutrition. She said she was not aware of Resident #17's weight loss until she looked at the weights on 9/13/17. She stated if she had known about Resident #17's weight loss she would have developed a care plan for nutrition and weight loss.

An interview was completed with MDS Nurse #2

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F 279	Continued From page 10 on 9/14/17 at 10:39 AM. The MDS Nurse #2 reviewed the nutrition CAA and stated due to Resident #17's poor nutrition, unstageable wound, poor meal intake, mechanical soft diet and that the resident needed encouragement to eat she thought Resident #17 was at risk for weight loss and a nutrition care plan should have been developed during the initial assessment and care plan period in July 2017. An interview was completed with the MD on 9/14/17 at 3:11 PM. The MD said she didn't recall being notified of the weight loss in August and she considered this to be a significant weight loss. The MD stated she expected the facility would have developed a care plan with interventions for the weight loss at the time the weight loss was documented. An interview was completed with the DON on 9/15/17 at 9:53 AM. The DON stated she would have expected a nutrition care plan to be developed with interventions and subsequently updated with weight loss and said, "I don't understand why one wasn't done."	F 279		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.	F 280		10/13/17

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F 280	Continued From page 11 (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to--	F 280		

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F 280	Continued From page 12 (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews the facility failed to update a care plan for one of 34 sampled residents (Resident #37). The findings included: Resident #37 was admitted to the facility on 4/11/13 with diagnoses of Alzheimer ' s Disease. Review of the Minimum Data Set (MDS), a quarterly, dated 7/11/17 indicated Resident #37	F 280	F280 Right to Participate Planning Care-Revise Care Plans Resident #37□s care plan was updated on 09/13/17 by the Minimum Data Set nurse (MDS) to show the current interventions that are in place. On 10/06/17, the Director of Nursing (DON), MDS nurse, staff facilitator and	

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F 280	Continued From page 13 had short and long term memory problems, required extensive assistance with activities of daily living. Review of the care plan dated 8/2/17 for a problem of risk for falls included the use of a fall mat at bedside on the floor, and use of a rock-n-go chair for seating. The care plan included the resident care guide for use by the aides. The care guide indicated the resident was to have TEDs (compression stocking to reduce edema) and the fall interventions for a rock-n-go chair and a fall mat. Observations on 9/12/17 at 9:46 AM revealed Resident #37 was seated in a Geri-chair, the TEDs were not on the resident and a fall mat was not located in the room. Interview with aide #3 on 9/13/17 at 12:00 PM revealed Resident #37 had not had the fall mat for a long time and had been in a Geri-chair for a long time. She was not aware if the resident should have the TEDs on each day. 09/13/2017 11:55:06 AM interview with MDS nurse revealed when the care plan was last updated, she thought the interventions were still in use by staff. Since reviewing the care guide and care plan, the fall mat should be discontinued, the TED hose should be discontinued due to a pressure ulcer on her heel, and the chair should be changed from rock n go to a Geri-chair. Further interview revealed she did not know when the changes occurred.	F 280	corporate consultant initiated a 100% audit of resident records to identify if any resident needing to have the care plan updated to include or changes to any mobility aide, fall intervention, and/or compression hose. On 10/05/17, the corporate consultant completed and in-service with the MDS nurse, treatment nurse, and DON on updating the care plans with current conditions of the residents. The in-service includes the need to update care plans with the current status of the resident. The DON and/ or staff facilitator will review physician orders and twenty four hour report in morning clinical meeting to effectively communicate with the interdisciplinary team any changes in resident status. On 10/9/17 an audit of 25% of residents will be conducted weekly times 4 weeks, then every two weeks for 4 weeks, then 10% monthly times 2 months by the DON. This is to ensure compliance and completion of comprehensive assessments after significant changes. All identified areas of concern will be addressed immediately by the DON through retraining to the MDS nurse. Corrections will be made as identified. The results of the audits will be presented by the administrator and/or the DON at the monthly Quality Improvement meeting for recommendations.	
F 325	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS	F 325		10/13/17

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F 325 SS=D	Continued From page 14 UNLESS UNAVOIDABLE (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, physician, dietitian and staff interviews and record review, the facility failed to put nutritional interventions into place to address recorded weight loss for 1 of 4 residents (Resident #17) reviewed for nutrition; and failed to follow through with the Registered Dietician's recommendation to increase Resource 2.0 (nutritional supplement) due to weight loss for 1 of 4 sampled residents (Resident #68) reviewed for nutrition.. Findings included: 1. Resident #17 admitted to the facility on 7/14/17 with diagnoses that included, in part, malnutrition, depression, and pressure ulcer of	F 325	F325 Maintain Nutrition Status Unless Unavoidable On 10/06/17, resident #17□s care plan has been updated by the Minimum Data Set (MDS) nurse to include weight loss and supplements. On 10/6/17, an audit was completed by the Director of Nursing (DON), MDS nurse, staff facilitator, and treatment nurse to check care plans to ensure that weight loss and supplements had been care planned to reflect the current status of the resident. On 10/05/17, the corporate consultant	

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F 325	Continued From page 15 unspecified ankle, unstageable. A review of the comprehensive Minimum Data Set (MDS) assessment dated 7/21/17 revealed Resident #17 had moderately impaired cognition and needed supervision with set up assistance for eating. Further review of the MDS revealed Resident #17 was 69 inches tall and weighed 136 pounds. A review of the care plan revealed no current care plan that addressed nutrition. A review of the Care Area Assessment (CAA) worksheet dated 7/26/17 revealed Resident #17's state of nourishment was poor due to poor oral intake, a supplement was provided twice a day, there was an unstageable wound, the resident ate 0-25% of most meals, needed to be supervised during all meals and received diuretics. Further review of the CAA revealed that nutritional status would not be addressed in the care plan since supplements were provided and there was no weight loss at the time the CAA was completed. A review of the medical record revealed the weights for Resident #17 were as follows: 7/18/17 weighed 136 pounds, 8/25/17 weighed 124 pounds and 9/11/17 weighed 122 pounds. This reflected a 14 pounds/10% weight loss between 7/18/17-9/11/17. A review of the diet ordered by the physician dated 7/15/17 revealed, "mechanical soft, no added salt, thin liquids." A review of nurse's note dated 7/14/17 revealed, "Resident will require tray set up but is able to feed herself, although she has poor appetite. Resident has a pressure wound on right lateral	F 325	in-serviced the DON, MDS nurse, staff facilitator, and treatment nurse concerning updating care plans and reviewing physician orders in morning clinical meeting with the interdisciplinary team to effectively communicate changes in resident condition. 10/11/17 per RD recommendations initiated changing nutritional supplements on #17 and #68 to be given during medication pass and intake percentage will be documented on the MAR. 10/11/17 resident's weight loss, supplement changes, RD recommendation, notify the physician and dietary supplemental assessment will be monitored through our weekly quality of care meeting. Corrections will be made as identified. On 10/09/17, the DON, MDS nurse, staff facilitator, and/or treatment nurse will monitor 25% of residents using the Care Plan Audit Tool weekly times 4 weeks, then twice weekly times 4 weeks, and then once monthly times 3 months. Corrections will be made as identified. The results of the audits will be presented by the administrator and/or DON the monthly QI meeting for recommendations.	

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ankle. She has a lot of edema in lower extremities (2+) and sacral area (2+)."

A review of the physician's (MD) history and physical note dated 7/17/17 revealed diagnoses of "cellulitis left lower extremity; edema-minimal at present; malnutrition-recent weight loss."

A review of the dietary assessment dated 7/26/17 revealed, "Average daily intake 1-25%; leaves 25% food uneaten at most meals; on a planned weight loss/gain program. Meal tray set up. Supervised during all meals. New admission to facility. Resident receives a supplement with meals twice a day due to poor oral intake. She has a surgical wound, unstageable. Much encouragement needed for resident to eat. Goal is for no weight loss."

A review of the Registered Dietician (RD) note dated 8/8/17 revealed, "Unstageable pressure ulcer right lateral malleolus (ankle). Recommend multi-vitamin with mineral every day, vitamin C 500 milligrams (mg) times 14 days then discontinue, zinc sulfate 220mg daily times 14 days then discontinue and sugar free prostat 30 milliliters (ml) daily to help promote healing."

A review of the medical record revealed there was no documentation that indicated the MD was notified of Resident #17's 12 pound weight loss between 7/18/17 and 8/25/17.

A review of MD note dated 9/4/17 revealed, "Appetite good, weight fluctuates, continue to monitor."

An interview was completed with Nurse Aide (NA) #1 on 9/13/17 at 11:52 AM. She stated Resident

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#17 fed herself after staff set up her meal tray. NA #1 said the resident typically ate well at breakfast but not much at lunch and that Resident #17 preferred to eat in her room.

An interview was completed with NA #3 on 9/13/17 at 11:56 AM. She had checked on Resident #17 while she ate her lunch and reported the resident fed herself after tray set up by staff. NA #3 said Resident #17 ate well if it was something she liked and staff offered an alternate food item if they observed her not eating well.

On 9/13/17 at 12:02 PM an observation was made of Resident #17 as she ate lunch. Her meal consisted of steak that had been cut into bite size pieces, mashed potatoes, okra, roll, cake and tea. An interview was completed with Resident #17 while she ate her lunch. She was hard of hearing and communicated by written note. She stated she liked the food at the facility. When asked if she got enough to eat during the day Resident #17 did not respond.

On 9/13/17 at 12:22 PM an observation was made of NA #3 when she picked up Resident #17's lunch tray. NA #3 asked the resident if she was finished eating and the resident responded that she was done. The resident ate almost all of the potatoes, about 25% of the okra and a few bites of the steak. She ate all of the dessert. She didn't eat the roll. She drank most of the tea. NA #3 did not offer an alternative food option for what resident didn't eat or ate very little of (meat, roll).

An interview was completed with Nurse #1 on 9/13/17 at 2:55 PM. She reported resident was "definitely one to have to be encouraged to eat."

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She stated when she observed a resident with weight loss she notified the MD and requested an order for a nutritional supplement.

An interview was completed with the RD on 9/13/17 at 3:40 PM. She reported she came to the facility once a month and reviewed the dietary assessments completed by the Certified Dietary Manager (CDM). The RD stated if she had a recommendation after she reviewed the CDM's assessments she wrote a note in the computer and sent the recommendation information to the Director of Nursing (DON). The RD said she saw Resident #17 on 8/8/17, prior to the documented weight loss. Her next visit with Resident #17 was 9/12/17, 18 days after the documented 12 pound weight loss and she recommended Resource 2.0 three times daily between meals.

An interview was completed with the CDM on 9/13/17 at 4:51 PM. She stated after a resident was admitted to the facility she completed a dietary assessment within 5-7 days. When she completed Resident #17's assessment she noted that the resident had poor intake and therefore she recommended a health shake. She stated Resident #17 didn't have a good appetite upon admission. "My concern was low weight and not eating well, that's why I recommended health shake for more calories. My focus was on supplement for poor oral intake." The CDM further stated she found out about weight loss if Nursing notified her or if she generated a monthly report of those with weight loss. The data for the monthly weight reports came from the NA's who entered the weights into the computer system.

A second interview was completed with the CDM on 9/14/17 at 9:31 AM. She said she was not

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aware of Resident #17's weight loss until she looked at the weights on 9/13/17. She stated if she had known about Resident #17's weight loss she would have started a care plan and asked for a physician ordered supplement.

An interview was completed with the Administrator on 9/14/17 at 10:02 AM. She stated the facility didn't specifically write down the percentage of supplement consumed if the supplement came out on a resident's meal tray and said the percentage of the meal consumed included the supplement.

A second interview was completed with NA #1 on 9/14/17 at 11:40 AM. She reported she weighed all residents by the 10th of each month. She said if she noticed a weight loss she notified the Administrator, DON and kitchen staff and then re-weighed the resident. She documented weights in the electronic medical record. She said when she saw the change in Resident #17's weight on 8/25/17 that she thought she notified Nurse #1. NA #1 stated MDS Nurse #2 saw the weight and asked for the resident to be re-weighed. NA #1 reported she re-weighed the resident and verified the weight was correct.

An interview was completed with MDS Nurse #2 on 9/14/17 at 11:54 AM. She stated she looked at Resident #17's weights after the 12 pound weight loss and remembered that the resident was admitted with 2+ pitting edema to her legs and had cellulitis.

An interview was completed with the MD on 9/14/17 at 3:11 PM. The MD stated Resident #17's weight loss was probably a combination of nutrition and fluid loss from edema. The MD said

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she initially saw the resident on 7/17/17 and then saw her again about two weeks ago. On the initial visit the MD said Resident #17 didn't have edema but had some induration. She stated the resident's appetite was not great and she ate 50-60 percent of meals. The MD said she didn't recall being notified of the weight loss in August and she considered this to be a significant weight loss. The MD stated she expected the facility would have developed interventions for the weight loss at the time the weight loss was documented.

A second interview was completed with Nurse #1 on 9/14/17 at 3:36 PM. She said she had not been notified of Resident #17's 12 pound weight loss in August.

A second interview was completed with MDS Nurse #2 on 9/14/17 at 3:40 PM. She stated at the time of Resident #17's weight loss she was acting as both the DON and MDS nurse and couldn't recall if she notified anyone of the weight loss.

A second interview was completed with the physician on 9/15/17 at 8:45 AM. She said she had researched Resident #17's medical record and thought the admission weight of 136 pounds was not the resident's true body weight. She said "It was probably excess fluid; per the discharge summary she had quite a bit of edema; she also had diastolic dysfunction." The MD stated she thought fluid played a significant part in the weight loss, "not to say nutrition didn't play a part."

During a follow up interview with the physician on 9/15/17 at 8:58 AM she revealed that Resident #17's edema had resolved and the additional 2

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pound weight loss in September was because the resident had declined and was frail. She said Resident #17 was only eating 50-60% of her meals. The MD said she had not diagnosed the resident with failure to thrive.

An interview was completed with MDS Nurse #2 and DON on 9/15/17 at 9:53 AM. MDS Nurse #2 stated she didn't remember being told about the 12 pound weight loss. "I think it just got missed. It should have been communicated we could have called the doctor. We should have communicated that to the doctor." The DON said she would have expected that the person who took the weight would have immediately notified the nurse, who would then have notified the MD, DON and MDS Nurse. The DON further stated she would have expected a care plan to be developed with nutritional interventions and subsequently updated with weight loss and said, "I don't understand why one wasn't done."

2. Resident #68 was admitted to the facility on 9/1/15 with diagnoses which included: Alzheimer's dementia, dysphagia, adult failure to thrive, anorexia, aspiration, and feeding difficulties.

Review of the Registered Dietician's Note dated 6/13/17 revealed Resident #68 had a 13% weight loss within a 180 day period. The resident's weight of 87 pounds on 5/9/17 indicated a 13 pound weight loss in comparison with the resident's weight of 100 pounds on 11/14/16. As an intervention, the Registered Dietician (RD) recommended an increase of Resource 2.0 (nutritional supplement) to 240 ml (milliliters) between meals, three times a day to provide 1440 calories and 60g (grams) of protein.

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The annual Minimum Data Set (MDS) dated 6/20/17 indicated Resident #68 was severely, cognitively impaired; required limited assistance with eating; was 58 inches in height; weighed 91 pounds; and received a mechanically altered diet.

The Care Plan with a target date of 7/11/17 revealed Resident #68's nourishment was less than the body's requirement characterized by weight loss, inadequate intake, decreased appetite related to mechanically altered diet, cognitive impairment, difficulty in swallowing, and the resident would leave 25% or more of food uneaten at most meals. Interventions included: provide therapeutic/non-therapeutic supplements.

There was no documentation in the clinical records, the physician orders or the medication administration records indicating the facility followed-up with the RD's recommendation for Resident #68 to receive Resource 2.0, three times a day, between meals.

During an interview on 9/13/17 at 5:02 p.m., the RD revealed she last reviewed Resident #68's clinical record, including weights in June 2017, when the resident was referred to her (RD) due to a significant weight change of 13% weight loss. As a result of the resident's weight loss, the RD stated she recommended the resident receive Resource 2.0, 240 ml three times a day, between meals. The RD indicated she had not received any more referrals concerning this resident's weights. The RD also revealed that the Dietary Manager (DM) was responsible for completing the dietary supplemental assessments. The RD revealed that she (the RD) would then be notified and would review the dietary assessment if a

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resident had a significant weight loss, pressure ulcer, or was newly admitted to the facility.

During a meal observation on 9/14/17 at 12:00 p.m., Resident #68 in the dining room in a wheelchair feeding herself butter pecan, magic cup (nutritional supplement). The resident was observed refusing encouragement from staff to eat some of the pureed meal on her sectioned plate. She also refused to drink any of her whole milk. The resident did consume some of her chocolate pudding and some of her iced tea.

During an interview on 9/14/17 at 3:50 p.m., the DM revealed Resident #68 received a pureed diet with thin liquids and received a magic cup with every meal. She stated that she was not aware that the resident was to receive Resource 2.0. The DM stated the dietary department no longer provided nutritional supplements between meals to residents. The DM also revealed Resource 2.0 was routinely ordered by Dietary but was given to residents by the nurses during medication administration.

During a telephone interview on 9/15/17 at 9:08 a.m., the Physician stated that she visited the Resident #68 on 7/24/17 and the nutritional supplement received by the resident was magic cup three times a day. She indicated the resident's weight loss was due to underlying dementia. The Physician further indicated the resident's weight returned to 91 pounds in June 2017 and since then, had been stable in the low 90 pound range. The Physician revealed the Nurse Practitioner (NP) would sign most of the orders. She stated that the NP documented that she (NP) visited the resident on 8/28/17 and the resident was receiving a supplement of magic

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F 325	Continued From page 24 cup three time a day with her meals. When questioned about the RD's recommendation for the resident to receive the supplement, Resource between meals, three times a day, the Physician responded that sometimes when we "overdo supplements," residents would refuse to take them. During an interview on 9/15/17 at 9:40 a.m., the Director of Nursing (DON) stated once a month, the RD would assess new residents, residents with wounds and residents with weight loss. The RD would then send an email to the DON, Administrator and the DM consisting of the RD's list of recommendations and a request that within 5-7 days upon receipt of email, she (RD) would receive a follow-up from the facility that these recommendations were followed through. The DON stated that she (DON) or the nurses would write the RD recommendations as telephone orders and place the telephone orders in each of the residents' medical charts for the Physician to sign. The DON stated no one from the facility followed up with an email to the RD and the RD's recommendation for Resource 2.0 was never written as a Physician's order. After review of the Medication Administration Records (MARs), the DON confirmed the Resource 2.0 was never given to Resident #68.	F 325		
F 367 SS=D	483.60(e)(1)(2) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN (e) Therapeutic Diets (e)(1) Therapeutic diets must be prescribed by the attending physician. (e)(2) The attending physician may delegate to a	F 367		10/13/17

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F 367	Continued From page 25 registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to provide a renal diet per dialysis order for one of one residents receiving dialysis (Resident #56) and failed to provide physician ordered supplements for one of six sampled resident reviews for nutrition (Resident # 37). The findings included: 1. Resident #56 was admitted to the facility on 1/30/16 with a diagnosis of end stage renal disease. Review of the Minimum Data Set, an annual, dated 8/22/17 indicated Resident #56 had no short or long term memory problems, received a therapeutic diet and received hemodialysis treatment. Review of the Care Area Assessments dated 8/22/17 indicated Resident #56 received a regular diet. A decision was made by the care plan team to not proceed to care planning. Review of the care plan dated 8/22/17 for a problem of end stage renal disease included an intervention for a diet as ordered. Review of a telephone order dated 2/7/17 the diet order "per dialysis/ (name of dialysis center) included 1500 ml fluid restriction every day limit milk intake to 4 ounces every day. Diet No Added Salt (NAS) minimize tomato, tomato products,	F 367	F367 Therapeutic Diet Prescribed by Physician Resident #56 and #37□s diet order was clarified by the Director of Nursing (DON) on 09/30/17. The DON will review physician orders in clinical morning meeting to communicate changes in diet to interdisciplinary team. On 09/25/17, a 100% audit was completed by the DON and the corporate consultant of diet orders against meal tray cards to include supplements and to ensure accuracy. The results of the audit concluded that numerous diet orders needed to be clarified with the physician. Those orders were obtained on 09/30/17 and corrected in electronic medical record as well as meal tray cards by corporate consultant. On 10/06/17, the corporate consultant in-serviced the DON, MDS nurse, staff facilitator, and treatment nurse and dietary staff regarding providing the correct diet and supplement to the resident according to physician order. Beginning on 10/09/17, the DON, MDS nurse, staff facilitator, and/or treatment nurse will monitor 25% of resident meal trays using the Resident Diet Audit weekly	

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F 367	Continued From page 26 white and sweet potatoes, bananas, oranges, orange juice, dried starchy beans, peanut butter, aim for 10 ounces protein every day/preferred juices: cranberry/apple." Review of the September 2017 monthly orders signed by the physician included a diet "Regular NAS." Observations on 9/13/17 at 12:40 PM revealed Resident #56 had a lunch tray that included lima beans, okra and Salisbury steak. The resident was sleeping during lunch and did not eat her lunch. Interview with the Dietary Manager on 9/13/17 at 12:54 PM revealed Resident #56 should receive a renal diet with restriction of 1500 milliliters (ml) of fluid. Review of the tray ticket revealed a renal diet was to be provided by the dietary department for her meals. Further interview revealed the resident should have received green beans instead of lima beans. The dietary aide had misread the tray ticket and provided the wrong vegetable. Interview with the Dietary Manager on 9/14/17 at 10:00 AM revealed she had instructions posted for the dietary aides to guide them in what items could not be on a renal diet. One of the lists "Foods High In Phosphorus" indicated "AVOID Dried Beans" which included "lima beans." Further interview revealed she and the dialysis dietician communicated on the type of diet for Resident #56. The Dietary Manager explained she was providing the correct diet according to the communication she had with the dialysis dietician and physician. The resident was on a renal diet and should not have been given the	F 367	times 4 weeks, then twice weekly times 4 weeks, and then once monthly times 4 months. Corrections will be made as identified. The results of the audits will be presented by the administrator and/or DON at the monthly Quality Improvement meeting for recommendations.	

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F 367	Continued From page 27	F 367		

lima beans. Further interview revealed the Dietary Manager did not know why the current order was listed as "Regular NAS" and the order was in error.

2. Resident #37 was admitted to the facility on 4/11/13 with diagnoses of Alzheimer ' s Disease.

Review of the Minimum Data Set, a quarterly, dated 7/11/17 indicated Resident #37 had short and long term memory problems, required extensive assistance with eating and was on a mechanical altered diet.

Review of the care plan dated 8/16/17 for a problem of risk for weight loss included an intervention to provide supplements as ordered.

Review of the current (September 2017) monthly orders signed by the physician indicated Resident #37 had two supplements, Boost drink and magic cup, ordered. Boost was to be provided two times a day with meals and magic cup was to be provided three times a day with meals.

Observations on 9/10/17 at 6:00 PM revealed Resident #37 had the supplement Boost drink on her tray and was offered the supplement.

Observations on 9/15/17 at 1:05 PM revealed Resident #37 had the supplement Boost drink on her tray. Interview with aide # 4 who was feeding the resident revealed the resident did not receive a magic cup on her tray. Further interview revealed she did not remember Resident #37 having a magic cup on the tray when she had fed her in the past.

Interview on 9/15/17 at 1:07 PM with the Director

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F 367	Continued From page 28 of Nursing revealed the resident was ordered the magic cup and should have had it on the tray. Interview with the Dietary Manager on 9/15/17 at 1:30 PM revealed she checked the dietary communications and the order for the magic cup was not received by dietary. Further interview revealed she was not aware the resident had an order for the supplement. The supplement in the dietary system as an order was for Boost. The Dietary Manager explained both supplements would have been provided by dietary to the resident.	F 367		
F 371 SS=F	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. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other	F 371		10/13/17

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F 371	Continued From page 29 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 maintain sanitary conditions in the kitchen by not ensuring resealed containers of foods in the walk-in cooler were dated; by not properly storing food service cleaning supplies; and by not ensuring dishes and utensils were cleaned, sanitized and free from contamination. Findings included: 1. During the tour of the kitchen on 9/10/17 at 3:05 p.m., there were 2-five pound, resealed containers of pimento cheese spread and 1-five pound, resealed container of chicken salad that were not dated in the walk-in cooler. 2. During observations of the kitchen on 9/10/17 at 3:15 p.m. and on 9/15/17 at 3:10 p.m., the chemical/mop closet contained multiple plastic containers of dishwashing liquid and bleach stored on the floor beneath a storage rack and 3-large plastic containers of drying agent concentrate stored on floor near the door. There were also 6-brooms (with the broom heads on the floor) propped against the wall and not on the broom rack in the closet. On 9/15/17 at 3:15 p.m., the Dietary Manager (DM) confirmed the containers should not have been stored on the floor of the closet and the brooms should be hanging from the broom rack that was attached to the wall in the closet.	F 371	F 371 Food Procure, Store/Prepare/Serve - Sanitary On 09/15/17, corporate consultant removed undated food (2-five pound, resealed containers of pimento cheese spread and 1 five pound, resealed container of chicken salad) in the walk-in-cooler, properly stored the food service cleaning supplies, and began using the appropriate sanitizing strips. On 9/26/17 the administrator initiated in-serviced of 100% of dietary staff on storage of food service cleaning supplies, dating/labeling food, washing hands and using the appropriate sanitizing strips. All future dietary employees will be educated during their orientation process by the staff facilitator on storage of food service cleaning supplies in the chemical storage room, proper storage of mops/brooms, washing hands between clean & dirty duties, dating/labeling food, and using the appropriate sanitizing strips. On 10/09/17, the administrator initiated an in-service on the Dietary Audit Tools tool which will be utilized by the maintenance director. This tool includes checking for storage of food service cleaning supplies, dating/labeling food, and using the appropriate sanitizing strips. Any negative findings will be addressed immediately.	

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F 371	Continued From page 30 3a. On 9/13/17 at 11:38 a.m. during a kitchen observation, the male dietary staff was observed placing a rack of soiled dishware into the dishwashing machine then removing a rack of clean dishware (which included a coffee urn) from the machine without washing his hands. He (dietary staff) removed the coffee urn from the rack of clean dishes without washing his hands and placed it on the kitchen counterspace, next to the beverage dispensers. During a second observation on 9/13/17 at 12:03 p.m., the male dietary staff placed a rack of soiled meal trays into the dishwashing machine. When the rack of trays exited the dishwashing machine, the same dietary staff removed the cleaned meal trays from the rack without washing his hands. The Dietary Manager (DM) acknowledged the dietary staff was to wash his hands after handling soiled dishware before removing clean dishes from the dishwashing machine. The DM stated the dietary staff would be inserviced on avoiding "cross contamination" when using the dishwashing machine. 3b. During a kitchen observation on 9/14/17 at 12:20 p.m., a dietary staff was noted washing serving utensils in the three compartment sink. When asked what type of sanitizer was currently in the third compartment, the Dietary Cook and the Dietary Manager (DM) revealed the sanitizer used to wash dishware in the kitchen was a quat (quaternary ammonium) solution. However, the Dietary Cook was observed using a chlorine test strip to determine if the level of quat solution in the third compartment of the sink was at an appropriate strength. The Dietary Cook indicated the chlorine test strips were the test strips she	F 371	On 10/09/17, the director of nursing (DON), quality improvement (QI) nurse, maintenance director, dietary manager, corporate consultant, RN, initiated a QI tool titled, Dietary Audit Tools to ensure proper storage of food service cleaning supplies, dating/labeling food, and using appropriate sanitizing strips. This Dietary Monitoring tool will be completed weekly x 4 weeks, twice monthly x 8 weeks. Any negative findings will be addressed immediately. The administrator will monitor for proper completion and follow up of the Dietary Audit Tool by initialing the bottom right hand corner of the audit tool. Corrections will be made as indicated. The results of the audits will be presented by the administrator and/or DON the monthly QI meeting for recommendations.	

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F 371	Continued From page 31 used to check the level of sanitizing solution in the sink. During an interview and observation on 9/14/17 at 12:40p, the DM stated the quat test strips and not the chlorine test strips should have been used to ensure the strength of the quat sanitizing solution was at least 200 ppm (parts per million). A request to review the daily log used when testing the level of sanitizing solution in the three compartment sink resulted in the DM revealing the dietary department did not maintain a daily log of the concentration of the sanitizing solution used in the three compartment sink. The DM was able to locate the quat test strips in another area of the kitchen. When the DM dipped one of the quat test strips into the quat sanitizing solution in the sink there was no color change to indicate the strength of the solution. After several unsuccessful attempts to unclog the tubing connecting the sanitizer pump to the sink, the DM stated until the pump could be repaired, the pots, pans and utensils would be rewashed in the dishwashing machine.	F 371		
F 431 SS=D	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 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,	F 431		10/13/17

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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.

(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

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F 431	Continued From page 33 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to maintain medication temperatures between 36 degrees and 46 degrees Fahrenheit (F) for two of two medication refrigerators, failed to date opened medications, failed to remove expired medications in two of two medication carts and two of two medication rooms. The findings included: Observations of the middle hall medication cart on 9/14/17 at 11:15 AM revealed a plastic medication bag with a label for injectable Phenergan (anti-nausea medication) contained the injectable Phenergan single dose vials and Phenergan tabs 12.5 milligrams. The label gave directions for administration of the injectable Phenergan and there was not a label with a resident ' s name or directions for administration for the Phenergan tabs. One bottle of Mytab was expired, with an expiration date of 8/17. Observations of the middle hall medication room on 9/1417 at 11: revealed the medication refrigerator did not have a temperature log available for the month of September. Inspection of the refrigerator revealed the thermometer on the inside door of the refrigerator registered 30 degrees F. The medications inside the refrigerator included vials of injectable insulin (diabetic medications) and tubersol (for a TB skin test). The instructions on the box containing the tubersol indicated it should be stored at 35 to 46 degrees F and gave a "Do not freeze" warning. The insulin label indicated "Avoid freezing."	F 431	F431 All medications to include Phenergan, Mytab, Xalatan eye drops, Lidocaine, and Brovanna were removed and discarded by the Director of Nursing on 09/15/17. Refrigerator temperatures were checked by the Director of Nursing (DON) to ensure that temperatures were within normal ranges and medications were being properly labeled and stored in them, on 09/15/17. 100% audit of all medication carts and medication rooms was completed 09/15/17 by the Director of Nursing to ensure that medications were not expired and were dated upon opening if required. For any identified areas of concern during the audit, the medication was immediately removed, discarded and reordered from pharmacy by the Director of Nursing. This audit also included medications being stored in the refrigerators. On 09/26/17, 100% of licensed nurses were in-serviced regarding medication discard dates and which medications must be dated upon opening and when to discard due to expiration to include Phenergan, Mytab, Xalatan eye drops, Lidocaine, and Brovanna by the Director of Nursing and the Staff Facilitator. The education also included refrigerator temperature ranges and how often the refrigerators should be checked and	

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F 431	Continued From page 34 Medication opened and used included Novolog insulin multi-dose vial that was not dated when opened, dated when it would expire and no label that would include the resident ' s name and directions for administration. The insulins and tubersols were inspected with the pharmacy consultant during the time of observation. The pharmacy consultant explained the medications were not crystalized, which would indicate they were frozen. She further explained she would not be able to determine if the medications were stable to use, unless she knew how long they had been kept at 30 degrees F. Interview with nurse #1 on 9/14/17 at 11:25 AM, who was working on the middle hall, revealed she had not seen a log to record refrigerator temperatures for a long time. Further interview revealed she was not aware the temperature was 30 degrees. Observations on the back hall of the medication cart on at 9/14/17 at 11:31AM revealed the following: one bottle of Mytab (for gas relief) open and used with expiration date of 8/17, Xalantan eye drops not dated when opened and a multi-dose vial of Humalog insulin 100U/ml not dated when opened and no expiration date written on the medication. Observations of the back hall medication room on 9/14/17 at 11:57 AM revealed upon entry, the medication refrigerator door was opened, and could not be closed shut. Nurse #2 was asked to check the refrigerator. A box of medications was not placed in the refrigerator so that the door would close. Nurse #2 rearranged the box and closed the door. The temperature on the thermometer was at 40 degrees F, which was in	F 431	where the documentation should be kept. All newly hired licensed nurses will receive training during orientation by the Staff Facilitator regarding medication discard dates and which medications must be dated upon opening to include Phenergan, Mytab, Xalatan eye drops, Lidocaine, and Brovanna along with the refrigerator temperature procedure and documentation. The Director of Nursing, staff facilitator, and/or treatment nurse will monitor medication carts and medication rooms for dating of medications upon opening if required and expired medications utilizing the QI Expired\ Undated Medication audit tool weekly x 8 weeks and monthly x 1 month. Included in the monitoring will be Phenergan, Mytab, Xalatan eye drops, Lidocaine, and Brovanna along with refrigerator temperature check procedure and documentation. The licensed nurses will be re-educated by the staff facilitator for any identified areas of concern during the audit. The DON will review and initial the QI Expired\ Undated Medication audit tool weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of concern were addressed. Corrections will be made as identified. The monthly quality improvement (QI) committee will meet monthly and review the QI Epired/Undated Medication Audit Tool. The director of nursing and/or administrator will present the audit findings and any QI committee recommendations to the quarterly	

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F 431	Continued From page 35 range. A temperature log was present and gave parameters for the medication refrigerator to be at 36 degrees to 46 degrees F. Observations of the medication room on 9/14/17 at 11:57 AM revealed an expired medication, Kaopectate (anti-diarrheal) in a cabinet for use, with an expired date of 8/17. The medication had not been opened. Further inspection of the medication room revealed a large tray on top of the medication refrigerator. Inside the open tray were 3 multi-dose vials of muti-dose 1% Lidocaine (local anesthetic) that was opened and not dated when opened. An un-opened, unlabeled package of Brovanna (inhalation for nebulizer) was in one compartment of the tray. The inhalant package did not have a label indicating the name of a resident or directions for its use. Interview with Nurse #2 on 9/14/17 at 11:57 AM revealed she was not aware the door was not shut and did not know how long the door had been standing open. Interview with maintenance on 9/14/17 at 1:10 PM revealed he had not been notified of the medication room refrigerator temperatures had been at freezing in the past 3 months. He further explained the middle hall medication refrigerator was defrosted in August 2017. Interview with the Director of Nursing on 9/14/17 at 1:11 PM revealed she three months of medication refrigerator temperature logs. She explained the three checklist sheets were given to her and did not have a month and/or date on them. She did not know where they came from and were in with other papers. The DON	F 431	executive quality assessment and assurance (QAA) committee for two quarters for review, root cause analysis, and further recommendations.	

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F 431	Continued From page 36 explained the night nurses (11-7) were responsible for checking the medication refrigerators nightly. It was her expectation for the temperatures to be checked, and if out of range per the sheet instructions, the maintenance director would be notified. The middle hall medication refrigerator should have had the checklist for the temperatures to be checked every night.	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 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	F 441		10/13/17

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F 441	Continued From page 37 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. (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, record review and staff	F 441	F 441 Infection Control, Prevent Spread,	

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F 441	Continued From page 38 interviews the facility failed to follow infection control practices for residents with an infection (Resident #40) and suspected infection (Resident #17) requiring contact isolation and for two of two sampled residents (Residents # 40 and 17). The findings included: Review of the Infection Control Manual, dated 9/14 included in section VI, page 9, "Contact Precautions." The instructions included in part: "Utilize clean gloves when entering resident ' s room and during care, change gloves after contact with infectious materials such as fecal material ... which may contain high levels of a given microorganism, remove gloves and perform hand hygiene with soap and water before leaving resident area, wear a gown when entering room and caring for the resident, remove and dispose of gown before leaving the resident ' s room..." 1. Resident #40 was admitted to the facility on 8/3/2016 with diagnosis of Alzheimer ' s disease and recurrent Clostridium Difficile (C-diff) an infection of the bowel with diarrhea. Record review revealed an order dated 8/9/17 written and signed by the nurse practitioner to obtain a gastrointestinal consul (GI) due to ongoing episodes of C-diff, place on isolation, administer Vancomycin (antibiotic used to treat C-diff) and Floranex tab for loose stools. Review of an order dated 8/29/17 written and signed by the nurse practitioner to continue/restart oral Vancomycin until 9/14/17 per the GI recommendation from recent visit (Positive for C-diff).	F 441	Linens On 9/11/17 correct signage and PPE was place on Residents #40 and #17 doors. On 09/15/17, the Director of Nursing (DON) was immediately re-educated by the facility consultant on hand washing, proper personal protective equipment, and isolation signage. On 09/25/17, a 100% in-service was initiated by the DON for direct care staff on maintaining an effective infection prevention and control program in order to prevent and control to the extent possible, the spread of C-Diff, proper personal protective equipment and isolation signage. On 10/06/17 when RNs/LPNs take off an order for labs for any infectious disease they will place the proper signage and PPE on the resident's door. During morning clinical meeting orders will be reviewed and corrections will be made as identified. On 10/06/17, the DON initiated an Infection Control QI Monitoring Tool to monitor staff using the correct personal protective equipment, proper signage in place and orders written for isolation. The DON and/or administrator will use the Infection Control QI Monitoring Tool to audit every week x 4 weeks, twice monthly x 2 months, then monthly x 3 months. Any negative findings will be addressed immediately by the DON	

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F 441	Continued From page 39 Observations on 9/10/17 at 4:00 PM revealed a sign on the door to "see nurse before entering" and a container with gowns, gloves and masks was hanging on the door to the resident ' s room. Observations of NA#2 on 9/10/17 at 6:15 PM revealed he entered the room of Resident #40, and did not put on a gown or gloves. NA#2 proceeded to replace the items on the tray, cover it with the tray lid and removed the tray from the room. Observations of NA#2 continued after he placed the tray on the tray cart and he proceeded to another resident ' s room. NA#2 did not wash his hands after leaving Resident #40 ' s room or before going into another resident ' s room. Observations on 9/11/17 at 2:07 PM revealed a sign was posted on the room of Resident #40 for contact precautions. Observations on 9/11/17 at 5:34 PM revealed NA#3 went into the room of Resident #40 to give him his supper tray. She did not put a gown or gloves on after entering his room. Upon leaving his room, she used the hand sanitizer mounted on the hallway wall and proceeded to deliver trays to other residents. Interview on 9/13/17 at 3:07 PM with the Director of Nursing (DON) revealed she was instructed by the corporate nurse to use the signage "see nurse before entering room" on Resident #40 ' s door. She found out on Monday she was supposed to have the contact precaution sign on the door. Interview with NA#2 on 9/14/17 at 4:00 PM revealed he should have used the gown and gloves. He further explained he knew he should	F 441	and/or administrator. Corrections will be made as identified. The administrator and/or DON will bring results of audits to the monthly QI committee meeting to identify any trends and continued need for monitoring.	

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wash his hands with soap and water. The explanation provided as to why that was not done revealed he needed to get the trays out and could not let the trays "sit" on the hall. NA#2 was asked if he knew why the resident would be on isolation precautions and he replied for C-diff.

Interview with the Staff Development nurse on 9/13/17 at 2:37 pm revealed she does the quality assurance (QA) each month for infection control. The Staff Development explained the nurse who takes an order for isolation would be responsible for placing the contact precaution sign and PPE to be used at the resident's door. She did staff training on initial hire for orientation, but had not completed any further training for the employees on infection control.

Interview with the Administrator on 9/13/17 at 3:22 PM revealed due to changes in administration staff, a continuous infection control nurse was not in place. The last person to oversee infection control was the previous DON. The infections were tracked and trended by the Staff Development nurse for their quality assurance meetings monthly. Resident #40 was discussed in the meeting. Further interview revealed she would expect staff to use personal protective equipment (PPE) when in the room and wash their hands after caring for a resident on contact precautions. She explained she would expect to have a sign up at the door indicating what precautions were to be used by staff.

Interview with the DON on 9/15/17 at 2:17 PM revealed she would expect staff to use the PPE when entering a resident ' s room that required contact precautions. She explained it would not be sufficient to use hand sanitizer to cleanse

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hands, but would require use of soap and water for a resident with C-diff.

Based on observations, record review and staff interviews the facility failed to follow infection control practices for residents with an infection (Resident #40) and suspected infection (Resident #17) requiring contact isolation and for two of two sampled residents (Residents # 40 and 17)

The findings included:

Review of the Infection Control Manual, dated 9/14 included in section VI, page 9, "Contact Precautions." The instructions included in part: "Utilize clean gloves when entering resident ' s room and during care, change gloves after contact with infectious materials such as fecal material ... which may contain high levels of a given microorganism, remove gloves and perform hand hygiene with soap and water before leaving resident area, wear a gown when entering room and caring for the resident, remove and dispose of gown before leaving the resident ' s room..."

1.Resident #40 was admitted to the facility on 8/3/2016 with diagnosis of Alzheimer ' s disease and recurrent Clostridium Difficile (C-diff) an infection of the bowel with diarrhea.

Record review revealed an order dated 8/9/17

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written and signed by the nurse practitioner to obtain a gastrointestinal consul (GI) due to ongoing episodes of C-diff, place on isolation, administer Vancomycin (antibiotic used to treat C-diff) and Floranex tab for loose stools.

Review of an order dated 8/29/17 written and signed by the nurse practitioner to continue/restart oral Vancomycin until 9/14/17 per the GI recommendation from recent visit (Positive for C-diff).

Observations on 9/10/17 at 4:00 PM revealed a sign on the door to "see nurse before entering" and a container with gowns, gloves and masks was hanging on the door to the resident ' s room.

Observations of NA#2 on 9/10/17 at 6:15 PM revealed he entered the room of Resident #40, and did not put on a gown or gloves. NA#2 proceeded to replace the items on the tray, cover it with the tray lid and removed the tray from the room. Observations of NA#2 continued after he placed the tray on the tray cart and he proceeded to another resident ' s room. NA#2 did not wash his hands after leaving Resident #40 ' s room or before going into another resident ' s room.

Observations on 9/11/17 at 2:07 PM revealed a sign was posted on the room of Resident #40 for contact precautions.

Observations on 9/11/17 at 5:34 PM revealed NA#3 went into the room of Resident #40 to give him his supper tray. She did not put a gown or gloves on after entering his room. Upon leaving his room, she used the hand sanitizer mounted on the hallway wall and proceeded to deliver trays to other residents.

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Interview on 9/13/17 at 3:07 PM with the Director of Nursing (DON) revealed she was instructed by the corporate nurse to use the signage "see nurse before entering room" on Resident #40 ' s door. She found out on Monday she was supposed to have the contact precaution sign on the door.

Interview with NA#2 on 9/14/17 at 4:00 PM revealed he should have used the gown and gloves. He further explained he knew he should wash his hands with soap and water. The explanation provided as to why that was not done revealed he needed to get the trays out and could not let the trays "sit" on the hall. NA#2 was asked if he knew why the resident would be on isolation precautions and he replied for C-diff.

Interview with the Staff Development nurse on 9/13/17 at 2:37 pm revealed she does the quality assurance (QA) each month for infection control. The Staff Development explained the nurse who takes an order for isolation would be responsible for placing the contact precaution sign and PPE to be used at the resident's door. She did staff training on initial hire for orientation, but had not completed any further training for the employees on infection control.

Interview with the Administrator on 9/13/17 at 3:22 PM revealed due to changes in administration staff, a continuous infection control nurse was not in place. The last person to oversee infection control was the previous DON. The infections were tracked and trended by the Staff Development nurse for their quality assurance meetings monthly. Resident #40 was discussed in the meeting. Further interview

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revealed she would expect staff to use personal protective equipment (PPE) when in the room and wash their hands after caring for a resident on contact precautions. She explained she would expect to have a sign up at the door indicating what precautions were to be used by staff.

Interview with the DON on 9/15/17 at 2:17 PM revealed she would expect staff to use the PPE when entering a resident ' s room that required contact precautions. She explained it would not be sufficient to use hand sanitizer to cleanse hands, but would require use of soap and water for a resident with C-diff.

2. The facility Infection Control Manual, dated 8/2005 was reviewed. A review of section 6 of the manual revealed, "It is the policy of this facility to prevent the transmission of infection through the use of isolation precautions. Transmission based precautions will be utilized for known or suspected infections for which the route of transmission and/or prevention is known. Contact precautions in addition to standard precautions should be used for residents known or suspected with microorganisms that are easily transmitted by direct or indirect contact. Examples: Clostridium difficile (a bacteria that causes diarrhea)." A review of the facility's "Guidelines for Initiation of Precautions" revealed,

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"Inform facility staff of the initiation of precautions as indicated, ensure that appropriate supplies are available for use based upon precautions category, post appropriate signage on resident's room door and notify other departments as appropriate of precautions initiation for resident."
"Contact precaution recommendations include: utilize clean gloves when entering resident's room, remove gloves and wash hands before leaving resident area."

Resident # 17 was admitted to the facility 7/21/17 with diagnoses that included, in part, nausea with vomiting.

A review of physician's (MD) order dated 9/12/17 revealed, "Stool sample to test for clostridium difficile due to multiple loose stools."

On 9/13/17 at 11:49 AM an observation was made of Resident #17's room. There was no isolation sign posted on or near the door to the room nor any isolation supplies available at the entrance to the room. An observation was made of Nurse Aide (NA) #1 as she entered the room with Resident #17's lunch and set up the tray for the resident. NA #1 had no personal protective equipment on when she entered the room.

On 9/13/17 at 2:55 PM an interview was completed with Nurse #1. She stated that over the past couple of days Resident #17 had multiple loose stools. She said when there was a possibility that a resident needed contact isolation she notified her staff which included nurse aides. She was not sure of the facility protocol regarding a suspected contact isolation but thought it was good practice to treat the resident as contact isolation until the test results were back.

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On 9/13/17 at 3:30 PM an observation was made of Resident #17's room. There was a contact precautions sign on the door and hanging on the outside of the door was personal protective equipment supplies which included gowns, masks, gloves and red disposable bags.

On 9/15/17 at 10:55 AM an interview was completed with NA #1. She stated the procedure for contact isolation was to put on a gown and gloves before she entered a resident's room. She said the nurses informed the nurse aides when a resident was on contact precautions and a sign was placed on the door to the room. NA #1 said in the past a contact isolation sign and supplies were placed on the room door even if there was a suspected infection. She stated she was not notified by nursing staff prior to the sign being placed on Resident #17's door that there was a possibility of contact isolation.

An interview was completed with the Director of Nursing (DON) on 9/15/17 at 3:00 PM. She stated if there was suspected infectious disease, including clostridium difficile, a resident was placed on contact precautions. She said that until recently, she mistakenly thought she had to wait for the MD to order contact isolation. She reported that a stool sample was ordered for Resident #17 for suspicion of clostridium difficile but the resident wasn't placed on isolation precautions because the DON wasn't aware they had to until she reviewed the infection control manual. The DON said the facility didn't currently have an infection control nurse. She would have expected that once the order was given for the stool sample, the resident would have immediately been placed on contact precautions.

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F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and interview with the resident's representative for	F 514	F 514 Resident Records	10/13/17

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F 514	Continued From page 48 healthcare, the facility failed to maintain medical records with current dietary and advanced directive orders for three (3) of thirty-four (34) sampled residents. (Resident # 56, 37 and 68) The findings included: 1. Resident #56 was admitted to the facility on 1/30/16 with a diagnosis of end stage renal disease. Review of a telephone order dated 2/7/17 the diet order "per dialysis/ (name of dialysis center) included 1500 ml fluid restriction every day limit milk intake to 4 ounces every day. Diet No Added Salt (NAS) minimize tomato, tomato products, white and sweet potatoes, bananas, oranges, orange juice, dried starchy beans, peanut butter, aim for 10 ounces protein every day/preferred juices: cranberry/apple." Review of the September 2017 monthly orders signed by the physician included a diet "Regular NAS." Interview with the Dietary Manager on 9/14/17 at 10:00 AM revealed she had instructions posted for the dietary aides to guide them in what items could not be on a renal diet. One of the lists "Foods High In Phosphorus" indicated "AVOID Dried Beans" which included "lima beans." Further interview revealed she and the dialysis dietician communicated on the type of diet for Resident #56. The Dietary Manager explained she was providing the correct diet according to the communication she had with the dialysis dietician and physician. The resident was on a renal diet and should not have been given the lima beans. Further interview revealed the	F 514	On 9/15/17, the Director of nursing (DON) ensured Resident #68□s diet was clarified from the medication administration record (MAR). On 09/15/17, the Director of Nursing (DON) updated Resident #68□s electronic health record in Point Click Care (PCC) meal tray card system, showing diet and MAR to reflect the diet of pureed with mechanical snacks and thin liquids. On 09/25/17, DON and corporate consultant completed a 100% audit of each resident□s orders for the past 30 days against the meal tray cards to ensure orders had been reflected on MAR and electronic health record in PCC. On 09/25/17, the DON and/or staff facilitator began in-servicing 100% of licensed staff on correctly transcribing an order and ensuring the entire order is carried out, including if a diet is changed that it needs to be changed from the MAR and PCC correctly as well as the meal tray cards. This in-service will be completed by 10/13/17 by the staff facilitator. No licensed practical nurse (LPN) or registered nurse (RN) will be allowed to work after 10/13/17 until they complete the in-service. All LPN and RN new hires will receive in-service during new employee orientation by the staff facilitator. On 10/09/17, the DON, staff facilitator and/or staff nurse begin auditing 25% of resident orders for diet accuracy using the Diet Audit Tool. The audit will be	

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F 514	Continued From page 49 Dietary Manager did not know why the current order was listed as "Regular NAS" and the order was in error. 2. Resident #37 was admitted to the facility on 4/11/13 with diagnoses of Alzheimer's disease. Record review revealed a telephone order for Resident #3, dated 2/13/17, for a Do Not Resuscitate (DNR). Review of the current monthly orders for September 2017 indicated Resident #37 was to have full code and the monthly orders were signed by physician. A DNR form (goldenrod) for advanced directives was not found in the medical record. An interview was conducted with the responsible party (RP) on 9/15/17 at 12:38 PM revealed Resident #37 should be a full code. Interview with MDS nurse on 9/15/17 at 1:02 PM revealed she had spoken with the RP and the nurse practitioner for Resident #37. The MDS nurse verified Resident #37 was to be a full code. She explained she would remove the telephone DNR order from the chart. She wasn't sure why the resident had two different advanced directives. 3. Resident #68 was admitted to the facility on 9/1/15 with diagnoses which included: Alzheimer's dementia, dysphagia, adult failure to thrive, anorexia, aspiration, and feeding difficulties. Review of the quarterly Dietary Assessment dated	F 514	completed by the DON, staff facilitator, treatment nurse, staff nurse, administrator, and/or facility consultant 5x/week x 4 weeks then weekly x 4 weeks then monthly x 3 months. Any negative findings will be corrected immediately and physician will be notified. The results of the audits will be presented by the administrator and/or DON the monthly Quality Improvement meeting for the recommendations.	

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F 514	Continued From page 50	F 514		

5/26/17 indicated Resident #68 was to receive a regular diet of pureed consistency. The assessment also revealed the resident was edentulous.

The annual Minimum Data Set (MDS) dated 6/20/17 indicated Resident #68 was severely, cognitively impaired; required limited assistance with eating; had no swallowing problems; received a mechanically altered diet; and had no natural teeth.

The Care Plan with a target date of 7/11/17 revealed Resident #68's nourishment was less than the body's requirement characterized by weight loss, inadequate intake, decreased appetite related to mechanically altered diet, cognitive impairment, difficulty in swallowing, and the resident would leave 25% or more of food uneaten at most meals. Interventions included: provide therapeutic/non-therapeutic supplements.

Review of the September 2017's Physician's Order Sheet documented Resident #68 was to receive a mechanical soft diet with thin liquids; magic cup (nutritional supplement) on all trays; magic cup three times per day between meals for weight loss; and receive Restorative care with feeding due to poor appetite and weight loss.

During a meal observation on 9/14/17 at 12:00 p.m., Resident #68 was in the dining room, in a wheelchair feeding herself butter pecan, magic cup (nutritional supplement). The resident refused encouragement from staff to eat some of her pureed meal. A dinner roll of regular texture was observed in a saucer next to the resident's plated meal. The resident was observed taking a bite of the dinner roll. The resident was noted to

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be edentulous. However, the resident was able to chew and swallow the dinner roll without difficulty.

Review of the meal card which accompanied the resident's meal indicated Resident #68 was to receive foods of pureed texture.

During an interview on 9/14/17 at 3:50 p.m., the Dietary Manager (DM) revealed Resident #68 was to receive a regular diet of pureed texture with thin liquids and received a magic cup with every meal. The DM stated the dietary department no longer provided nutritional supplements between meals to residents.

During an interview on 9/15/17 at 9:40 a.m., the Director of Nursing (DON) stated that a review of the Medication Administration Records (MARs) for the months of June 2017 through September 2017 indicated Resident #68 was to receive a mechanical soft diet. The DON revealed she (DON) received clarification (on the morning of this interview) and the Speech Therapist wrote a clarification order that the resident was to receive a puree diet with thin liquids. The DON stated her expectation was that the resident should not have been served the dinner roll of regular texture because it was not appropriate with her ordered diet. Staff serving and setting up res meals are expected to review the resident's meal card ensuring the food items corresponds with what is written on the meal card. If there is a difference, the item is not to be served and the DM and the DON should have been immediately notified.

During an interview on 9/14/1 at 2:16 p.m., the Rehabilitative Manager stated Resident #68 was discontinued from Speech Therapy on 10/6/16. She revealed the resident was able to consume

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F 514	Continued From page 52 pureed solids and liquids with no signs of aspiration. Staff supervision with encouragement, when needed was recommended. She also revealed restorative feeding was not recommended for the resident by the Rehabilitative Department.	F 514		
F 520 SS=D	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 (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the	F 520		10/13/17

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F 520	Continued From page 53 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, staff interviews and record reviews, the facility's Quality Assessment and Assurance Committee (QA and Q) failed to implement, monitor and revise as needed the action plan developed for the recertification survey dated 8/18/16, in order to achieve and sustain compliance. This was for one recited deficiency on a recertification survey on 9/15/17. The deficiency was in the area of medication storage. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referenced to: F431: The recertification on 8/18/16 cited the facility for failure to securely store medications in one of two medication storage rooms. The recertification on 9/15/17 cited the facility for failure to maintain medication temperatures between 36 degrees and 46 degrees Fahrenheit (F) for two of two medication refrigerators, failed	F 520	F- 520 All medications to include Phenergan, Mytab, Xalatan eye drops, Lidocaine, and Brovanna were removed and discarded by the Director of Nursing on 09/15/17. Refrigerator temperatures were checked by the Director of Nursing (DON) to ensure that temperatures were within normal ranges and medications were being properly labeled and stored in them, on 09/15/17. 100% audit of all medication carts and medication rooms was completed 09/15/17 by the Director of Nursing to ensure that medications were not expired and were dated upon opening if required. For any identified areas of concern during the audit, the medication was immediately removed, discarded and reordered from pharmacy by the Director of Nursing. This audit also included medications being stored in the refrigerators. On 09/26/17, 100% of licensed nurses	

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F 520	Continued From page 54 to date opened medications, failed to remove expired medications in two of two medication carts and two of two medication rooms. Interview with the administrator on 9/15/17 at 3:20 PM revealed storage of medications and audits of the medication rooms and medication carts were not part of their current Quality Assessment and Assurance program.	F 520	were in-serviced regarding medication discard dates and which medications must be dated upon opening and when to discard due to expiration to include Phenergan, Mytab, Xalatan eye drops, Lidocaine, and Brovanna by the Director of Nursing and the Staff Facilitator. The education also included refrigerator temperature ranges and how often the refrigerators should be checked and where the documentation should be kept. All newly hired licensed nurses will receive training during orientation by the Staff Facilitator regarding medication discard dates and which medications must be dated upon opening to include Phenergan, Mytab, Xalatan eye drops, Lidocaine, and Brovanna along with the refrigerator temperature procedure and documentation. The Director of Nursing, staff facilitator, and/or treatment nurse will monitor medication carts and medication rooms for dating of medications upon opening if required and expired medications utilizing the QI Expired\ Undated Medication audit tool weekly x 8 weeks and monthly x 1 month. Included in the monitoring will be Phenergan, Mytab, Xalatan eye drops, Lidocaine, and Brovanna along with refrigerator temperature check procedure and documentation. The licensed nurses will be re-educated by the staff facilitator for any identified areas of concern during the audit. The DON will review and initial the QI Expired\ Undated Medication audit tool weekly x 8 weeks then monthly x 1 month for completion and to ensure all	

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F 520	Continued From page 55	F 520	areas of concern were addressed. The Quality Improvement Committee consist of the Interim Director of Nursing, Staff Facilitator, Minimum Data Set nurses, and Medical Record Supervisor. The Quality Improvement Committee will continue to meet at a minimum of monthly with the Executive QI committee meeting quarterly. The Executive QI Committee, including the Medical Director, will review monthly compiled QI report information, review trends, and review corrective actions taken and the dates of completion. The Executive QI Committee will validate the facility□s progress in correction of deficient practices or identify concerns. Any areas of concern that needs to be corrected or changed will be done at this time. The administrator will be responsible for ensuring Committee concerns are addressed through further training or other interventions. The administrator or her designee will report back to the Executive QI Committee at the next scheduled meeting.	