STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING _____ B. WING _____	C 10/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616

(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 165 SS=D	RIGHT TO VOICE GRIEVANCES WITHOUT REPRISAL CFR(s): 483.10(j)(1) (j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interviews and family interview the facility failed to investigate and resolve grievances for 1 of 1 resident that was reviewed for grievances (Resident #198). Findings Included: Resident #198 was admitted to the facility on 7/24/17 and diagnoses included cerebral vascular accident, hemiplegia, aphasia and cognitive deficit. A quarterly Minimum Data Set (MDS) dated 9/18/17 for Resident #198 identified she required extensive assistance with toileting, was always incontinent and her cognition was moderately impaired. A review of the grievance log for the past 3 months, provided by the facility Administrator, revealed a grievance dated 9/2/17 for Resident #198 that was submitted by her daughter / responsible party. The grievance documented	F 165	F165 This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. ROOT CAUSE This alleged noncompliance was resulted from the Center's Executive Director and the Director of Nursing misinterpretation of regulatory requirements related to investigation and resolving of resident's grievances. The Executive Director stated since Resident #198 potentially misplaced her dentures, the Executive	11/22/17

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

Electronically Signed | 11/17/2017

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F 165	Continued From page 1 that Resident #198 ' s bottom denture, wig and tennis shoes were missing. The grievance also identified concerns regarding the resident not being taken to the day room for her meals and provided with supervision with eating. The grievance additionally documented concerns regarding gloves and hand sanitizer being left on the floor in the resident ' s room, that the resident wasn ' t being toileted every 2 hours and had been found on several occasions soaking wet. The Director of Nursing (DON) was assigned to investigate the grievance on 9/2/17 and was dated as resolved on 9/11/17. The facility had a care plan meeting with the daughter to discuss her concerns at length, her mother ' s care plan was reviewed, and the Nursing Assistant (NA) assignment care card was updated. The facility discussed the resident ' s tendency to remove her wig and shoes and leave them in random places and other resident ' s rooms. Stated her wig and shoes were located and returned on 9/4/17. Resident was noted to be dry during checks with no saturation noted and she was being checked every 2 to 3 hours. A phone conversation and one to one discussion was conducted with Resident #198 ' s daughter. A nursing progress note dated 9/9/17 at 5:14 pm by Nurse #1 stated Resident #198 was alert with frequent confusion. She propelled herself in a wheelchair around the facility and was noted to misplace her personal belongings. Resident #198 ' s daughter called the facility and stated her mother ' s lower denture was missing. The resident ' s daughter was informed that they were aware and the staff were looking for her mother ' s lower denture. An observation of Resident #198 on 10/24/2017	F 165	Director thought there is nothing more she should have had to do. Regional Clinical Consultant re-educated the Center Executive director and the Director of Nursing on 10/26/2017 on facility grievance policies and procedures and the importance of completing thorough investigation. IMMEDIATE ACTION Resident #198 incontinent care was provided by Nurse Aide #6 and Nurse Aide #7. Resident #198 seen a dentist for denture evaluation and has an impression completed on 11/17/2017. Resident #198 grievance filed by the responsible party on 9/2/2017 re-opened by the administrator on 11/15/2017, actions taken to include appointment for impression scheduled for 11/17/2017 and incontinent care delivery added and resolved. This grievance was closed on 11/17/2017 by the Administrator per facility grievance policy. No other grievances voiced by resident #198 or her responsible party. IDENTIFICATION OF OTHERS 100% audit of all grievances filed by residents or family members within the last 30 days completed by the Executive director, Director of Social Services #1 and/or Director of Social Services #2 to determine any grievance that was not investigated and/or resolved per center’s grievance policy and procedures. The audit revealed that all other grievances filed within the last 30 days were investigated and resolved per facility	

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F 165	Continued From page 2 at 4:11 pm revealed she was sitting in a wheelchair at the nursing station. Her clothing appeared to be dry and no urine odor was noted. She did not have any dentures in her mouth. An interview on 10/24/2017 4:18 pm with NA #8 revealed she was familiar with Resident #198 and she had been her NA. She stated she recalled the resident ' s daughter talking about her mother ' s denture being missing, but wasn ' t sure if her denture was ever found or replaced. NA #8 stated that the resident wore briefs and was a "heavy wetter". She added that you needed to check her frequently to make sure she was not wet. An observation of incontinence care by NA #6 and NA #7 was conducted for Resident #198 on 10/25/17 at 2:15 pm. NA #6 and NA #7 explained the care they were providing, both NA ' s assisted with resident transfer from her wheelchair to the toilet, resident was provided with privacy and time to use the bathroom. Resident #198 was cleaned appropriately after toileting, a new brief was applied, and no skin concerns were identified during the observation. An interview on 10/25/17 at 5:09 pm with NA #5 revealed she was familiar with Resident #198. She stated the resident had an upper denture, but that her lower denture was missing. NA #5 added the resident didn ' t like to have her upper denture put in and that it seemed to make her gag. An observation of Resident #198 on 10/25/2017 at 5:24 pm revealed she was in the day room for her supper meal. Her clothing appeared dry and no urine odor was noted. An interview on 10/25/17 at 5:28 pm with Social	F 165	grievance policy and procedure. This audit will be completed by 11/22/17. Findings of this audit will be documented on grievance audit tool located at the facility compliance binder. SYSTEMIC CHANGES Effective 11/22/2017, the center Director of Social services #1, Director of Social services #2 and/or Executive Director, initiated a process for reviewing all filed grievances during daily department heads meeting. The center Director of Social services #1, Director of Social services #2 and/or Executive Director will review grievances filed last 24 hours or from the previous stand up meeting to ensure that, each grievance is assigned to a Department who will completed the investigation, and also will ensure that each assigned personnel is informed of the investigation needed to resolve each grievances. This systemic process will take place daily (Monday through Friday). Any identified issues will be addressed promptly and appropriate actions will be implemented by the center Director of Social services #1, Director of Social services #2 and/or Executive Director. This process will be incorporated in a daily Stand up meeting. Any negative findings will be documented on the daily “Stand up meeting” form and maintained in the “Daily meeting binder”. Director of Social services (#1, or #2), Executive Director, Director of Nursing (DON), Assistant Director of Nursing (ADON) and/or Staff Development	

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F 165	Continued From page 3 Worker (SW) #1 revealed that Resident #198 ' s daughter had informed her on 10/18/17 that her mother ' s lower denture was missing. She stated that the lower denture could not be located. SW #1 added the wound nurse told her today (10/25/17) that Resident #198 ' s upper denture did not fit well and was causing her some mouth pain. They had notified her daughter of that today (10/25/17) and were going to determine a time that the resident could go to the dental clinic for evaluation of the upper denture and replacement of the lower denture. SW #1 stated she was not aware that the Resident #198 ' s lower denture had been reported missing by her daughter on 9/2/17. An interview on 10/25/17 at 6:05 pm with Resident #198 ' s daughter revealed she had attended her mother ' s care plan on 9/2/17 and that was when she addressed her concerns identified on the grievance dated 9/2/17. She stated her mother ' s wig was found, but her shoes were never found and she had to buy her a new pair. Resident #198 ' s daughter added the facility had not addressed her mother ' s missing lower denture. She had called the Administrator and the DON multiple times after she had voiced her concerns and they never responded to her. She stated about 2 weeks ago she tried to meet with them and was told they weren ' t available at that time and she could meet with the Social Worker. Resident #198 ' s daughter stated that she told them she would just wait until they were available and eventually the Administrator and DON met with her. She stated during the meeting the Administrator told her the facility wasn ' t liable for replacing her mother ' s denture and she hadn ' t heard anything else back from the facility until yesterday, 10/24/17, about making arrangements	F 165	Coordinator (SDC) will complete 100% education for all current facility employees , to include full time, part time and as needed employees about facility grievance policy and procedure. The emphasis of this education was on the importance of documenting any voiced grievance by a resident and/or family member, and proper steps to be followed order to resolve each. Any employee not educated by 11/22/2017 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new employees effective 11/22/2017. MONITORING PROCESS Effective 11/22/2017, Executive Director and/or Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator, will monitor compliance by completing the audit of all completed/resolved grievances to ensure that an investigation was completed and grievance was resolved per facility grievance policy and procedure. This monitoring process will take place daily (Monday through Friday) for 2 weeks then 3x/week for two more weeks, then weekly for 2 weeks then monthly for 3 months or until the pattern of compliance is maintained. Any issues identified during this monitoring process will be addressed promptly. Findings from this monitoring process will be documented on a grievance audit form and filed in the facility compliance binder effective	

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F 165	Continued From page 4 for her mother to be seen by a dentist. She added her mother was still not being taken to the bathroom and she did occasionally find her soaking wet when she came to visit. An interview on 10/26/17 at 11:14 am with the Administrator revealed she had multiple, extensive conversations with Resident #198 ' s daughter. The Administrator stated she and the DON had met with her recently (wasn ' t sure of the date) and the residents daughter continued to have concerns with her mother ' s missing denture and continence care. She explained she did not document this as a new grievance because they were the same issues that were identified on the 9/2/17 grievance. The Administrator reviewed the initial grievance dated 9/2/17 that had been submitted and acknowledged that as of 10/26/17 there were ongoing concerns regarding the missing denture and continence care. She stated the facility had searched for the denture, but it was not found. She did not know why SS #1 stated the first she heard about the missing denture was on 10/18/17 when it had been identified on the 9/2/17 grievance. The Administrator added that Resident #198 ' s daughter had so many complaints and frequently talked to her and other staff members. She stated the daughters continued concerns should have been documented as a grievance and formally investigated.	F 165	11/22/2017. Effective 11/22/2017, Director of Social Services (#1 or #2), and/or Executive Director will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly X3 months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. RESPONSIBLE PARTY Effective 11/22/2017, the center Executive Director and the Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance. Compliance Date: 11/22/2017	
F 166 SS=C	RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES CFR(s): 483.10(j)(2)-(4) (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance	F 166		11/22/17

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F 166	Continued From page 5	F 166		

with this paragraph.

(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:

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

(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those

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F 166	Continued From page 6	F 166		

grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;

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

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

(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;

(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and

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F 166	Continued From page 7 (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility ' s grievance policy failed to include the grievance official ' s physical address and business e-mail address. Findings Included: The facility policy titled "Filing Grievances / Complaints" with a revision date of March 2017, was provided by the facility Administrator. The policy stated "Our facility will assist residents, their representatives, other interested family members, or advocates in filing grievances or complaints when such requests are made." The Administrator as the Grievance Official has the responsibility for oversight of the grievance and / or complaint investigation process." The facility procedure titled "Grievances" was provided by the facility Administrator and was not dated. The procedure stated "If you have any concerns, please contact our Grievance Coordinator: Facility Administrators Name and a phone number." A physical address and business e-mail address was not provided on the procedure. The facility "Resident/Family Grievance and Compliment Procedure" was provided by the facility Administrator and was not dated. The procedure stated "Our intention is to always provide the best of care to our residents and their families. Should you have concerns, grievances	F 166	F166C ROOT CAUSE This alleged noncompliance was resulted from the Center's Executive Director and the Director of Nursing misinterpretation of regulatory requirements related to posting of information specifically the grievance official name, address and business e-mail address. The center executive director indicated that the Grievance official name was posted but she did not post the address and e-mail address as those two items were not included in the facility grievance policy and procedure. IMMEDIATE ACTION TAKEN On 11/20/2017, Regional clinical consultant added an addendum to the facility current grievance policy and procedures to include the posting requirements that notates the name, physical address and business email address of the grievance official. On 11/20/2017, the grievance addendum was added on the policy and procedures located in the facility new admission package, at the binder located at the front desk and in the facility compliance binder. IDENTIFICATION OF OTHERS On 11/22/2017 All regulatory required policy and procedures to include	

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F 166	Continued From page 8 or compliments we ask that you contact the facility social worker or our Care line (toll free number listed)." This procedure was located in the facilities current admission packet. An interview on 10/26/17 at 11:05 am with the Administrator revealed she was the facility Grievance Official. She stated the grievance procedure was reviewed during the admission process and the procedure, including copies of the grievance form were posted in the front lobby. The Administrator acknowledged that the physical address and business e-mail address for the Grievance Official were missing from the grievance policy and stated they should be added.	F 166	grievance policy and procedures, Abuse prohibition policy and procedures and Admission, transfer and discharge policy and procedures reviewed by the Regional Clinical consultant to ensure they meet the intent of requirements of participation. All other reviewed policies and/or procedures noted to meet the intent of regulation. SYSTEMIC CHANGES Effective 11/22/2017, any revised policy and/or procedure will be reviewed by the Quality Assurance and Performance Improvement Committee (QAPI) to ensure each policy meet the intent of regulation before implementation. This Committee will include the minimum of The Facility Medical Director, Director of Health Services, Executive Director, Licensed Pharmacist and at least three other members. Effective 11/22/2017 information for grievance official to include name, physical address, phone number and business e-mail will be discussed during new admission process by the Admission Director, Business office manager and/or Administrative staff who complete admission package during admission. Effective 11/22/2017 The Grievance official information is publicly posted on prominent locations in the facility. Posted information include grievance official name, physical address, phone number, and/or business email address. Director of Social services (#1, #2),	

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F 166	Continued From page 9	F 166	Executive Director, Director of Nursing (DON), Assistant Director of Nursing (ADON) and/or Staff Development Coordinator (SDC) will complete 100% education for all current facility employees , to include full time, part time and as needed employees about facility grievance policy and procedure. The emphasis of this education was on the importance of ensuring each staff is aware of who the grievance official is and where the posting of such information are located. Any employee not educated by 11/22/2017 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new employees effective 11/22/2017. MONITORING PROCESS Effective 11/22/2017, Executive Director, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Director of Social Services (#1 or #2), will observe 5 the posting of Grievance official on all prominent locations daily (Monday through Friday) to ensure that such information remain in place. Findings from this monitoring process will be documented on a “daily posting observation form.” This monitoring process will take place daily (Monday through Friday) for 2 weeks then 3x/week for two more weeks, then weekly for 2 weeks then monthly for 3 months or until the pattern of compliance is maintained. Effective 11/22/2017, Director of Social Services (#1 or #2), and/or Executive Director will report findings of this	

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F 166	Continued From page 10	F 166	monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly X3 months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. RESPONSIBLE PARTY Effective 11/22/2017, the center Executive Director and the Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance. Compliance Date: 11/22/2017	
F 241 SS=D	DIGNITY AND RESPECT OF INDIVIDUALITY CFR(s): 483.10(a)(1) (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observations, resident, family and staff interview the facility failed to provide care in a manner to maintain the resident's dignity by not answering call bells timely for resident needing assistance with activities of daily living (Resident #133 and Resident # 198) and by allowing a resident to set in a wet diaper for 5.5 hours.(	F 241	F241D ROOT CAUSE This alleged noncompliance was resulted from the facility staff failed to answer call bell in a timely manner and attend to the resident's need. This was also resulted from facility failure to divide assignments	11/22/17

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F 241	Continued From page 11 Resident #126). This was evident by 3 of 3 residents reviewed for dignity. Findings included: 1. Resident # 126 was admitted to the facility on 9/18/17 with diagnoses of hypertension and congestion heart failure. A review of Resident #126 quarterly minimum date set (MDS) dated 10/16/2017, revealed the resident was cognitively intact. Resident #126 required extensive assistance with bed mobility, transfers, toilet use with two person, physical assist, and with locomotion, dressing and personal hygiene she required extensive assistance with two person physical assist. During an interview with Resident # 126 on 10/25/2017 at 11 AM, Resident #126 indicated on Sunday 10/8/17 she waited in her wheel chair for 5 hours for staff to change her. Resident #126 when she put on her call bell no one answered. Resident #126 indicated because she waited so long she soiled herself (with urine). Resident #126 indicated that her call bell was on and Nursing Assistant (NA) #2 came in, cut off her call bell and stated she would be back to change her. Resident #126 indicated that she knew how long it took because her personal cell had the correct time on it. Resident #126 indicated that was a bad feeling waiting so long to be changed. Resident #126 revealed she felt sad and down a lot in the facility because staff were so slow. Resident #126 indicted that all her concerns had been reported to the facility. The Nursing Assistant (NA) #2 who was assigned this Resident had been terminated.	F 241	according to acuity level to meet residents' need. IMMEDIATE ACTION TAKEN Resident #133 is no longer in the facility, resident was discharged on 11/10/2017. No other actions taken for this resident. Resident #126 is no longer in the facility, resident was discharged on 10/29/2017. No other actions taken for this resident. On 10/25/2017 Resident #198 incontinent care was provided by Nurse Aide #6 and Nurse Aide #7. IDENTIFICATION OF OTHERS On 11/20/2017, 100% of all current alert and oriented residents in the facility were interviewed by the Center Executive Director, Director of Social services (#1 or #2), Director of Nursing, Assistant Director of Nursing and/or Staff Development Coordinator to determine if any other resident voiced concerns about call bell responses. Six other residents complained of call bell not being answered in a timely manner. 100% audit of all grievances filed by residents or family members within the last 30 days completed by the Executive director, Director of Social Services #1 and/or Director of Social Services #2 to determine any grievance that involve resident being wet for extended period of time and determine whether or not such grievances were investigated and/or resolved per center's grievance policy and procedures.	

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	345529	A. BUILDING _____ B. WING _____	C 10/26/2017

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F 241	Continued From page 12 During an interview with the Social Worker on 10/25/2017 at 11:30 AM, SW indicated that Resident #126 had shared this incident with her and had issues about the staff mistreatment of her not providing care and not answering her call bell. SW indicated that the NA #2 had been terminated of because of the incident with Resident #126 and several others. During an interview with Director of Nursing (DON) on 10/25/17 at 4:30PM he indicated that his expectation were for all staff to answer call bell within 3-5 minutes. His expectation would be that all staff treat residents with respect and dignity all at times and provide care and treatment. 2. Resident #133 was admitted to the facility 2/19/16 with diagnoses of hypertension, diabetes, muscle weakness ad restless legs syndrome. Resident #133 Minimum Data Set (MDS) dated 10/25/17 revealed that resident was cognitively intact without short or long memory issues. The resident required extensive assistance with bed mobility transfers and toilet use with two + person physical assist. The resident was always incontinent of bladder and bowels An observation of Resident #133 on October 22, 2017 at 7:15 PM revealed she was sitting beside her bed with her call bell on. An observation on October 22, 2017 at 7:45 PM revealed Resident #133's call bell remained on and she was sitting by the door. During an interview with Resident #133 on October 22, 2017 at 7:47 PM she stated she had been waiting since 6:30 PM to be put to bed. Resident #133 revealed that she put her call bell	F 241	The audit revealed that all other grievances related to incontinent care and call bell responses filed within the last 30 days were investigated and resolved per facility grievance policy and procedure. This audit will be completed by 11/22/17. Findings of this audit will be documented on grievance audit tool located at the facility compliance binder. On 11/20/2017, the Center Executive Director, Director of Social services (#1 or #2), Director of Nursing, Assistant Director of Nursing and/or Staff Development Coordinator conducted the 100% observation of all current residents in the facility to determine if any other resident has any sign or indication of being soiled (with urine). The observation revealed that no other resident identified to be soiled (with urine). Findings of this audit will be documented on “resident observation tool” located at the facility compliance binder. SYSTEMIC CHANGES Effective 11/22/2017, Resident #198 is being toileted per plan of care and has not evidenced unmet needs related to call light response. On 11/20/2017, the Regional Clinical Consultant revised facility nursing assistant assignment to ensure that the staffing pattern corresponds with the acuity level. Effective 11/22/2017, the facility will utilize the revised assignment sheet and ensure that each assignment’s acuity level is	

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F 241	Continued From page 13 on around 7:00 PM and the staff cut it off. She added the staff told her they would be back in a few minutes to put her to bed. Resident #133 stated "That was over an hour age and I'm tired and ready to go to bed." During an interview with Nursing Assistant (NA) #4, on October 22, 2017 at 8 PM she revealed that she cut off Resident #133 call bell off around 7 PM and told her she would be back to put her to bed. NA #4 also indicated that she had to wait to get help to put Resident #133 to bed because she was two person assist. NA #4 indicated that she was still waiting on someone to help her put Resident #133 back to bed. Observation of Resident #133 on October 22, 2017 at 8:15 PM revealed she was being put to bed. During an interview with Resident #133 on October 22, 2017 at 8:25 PM she stated the staff was always short and you had to wait 30 minutes or more to be put to bed especially on the weekend. During an interview with Director of Nursing (DON) on October 25, 2017 at 4:30 PM he indicated that no resident should have to wait an hour and 45 minutes to be put to bed. DON indicated he would talk with staff about this. 3. Resident #198 was admitted to the facility on 7/24/17 and diagnoses included cerebral vascular accident, hemiplegia, aphasia and cognitive deficit. A quarterly Minimum Data Set (MDS) dated 9/18/17 for Resident #198 identified she required	F 241	maintained. The Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator and/or Unit Coordinators will adjust the assignment sheets whenever necessary to ensure that the acuity level is maintained effective 11/22/2017. Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator and/or Unit Coordinators will complete 100% education for all current facility employees, to include full time, part time and as needed employees about call bell responses. The emphasis of this education was on the importance of responding to resident's call bell when activated and ensure resident's needs are anticipated. Any employee not educated by 11/22/2017 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new employees effective 11/22/2017. Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator and/or Unit Coordinators will complete 100% education for all current nursing staff to include licensed nurses and certified nurse aides, to include full time, part time and as needed nursing employees about incontinent care. The emphasis of this education was on the importance of providing incontinent care for each resident in a timely fashion and ensure resident's needs are anticipated. Any nursing staff not educated by 11/22/2017 will not be allowed to work	

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F 241	Continued From page 14 extensive assistance with toileting, was always incontinent and her cognition was moderately impaired. During an interview with family on 10/25/2017 at 6:05 PM revealed concerns with call bell and waiting to long for care and treatment to be provide to Resident #198.Family indicated that we met with the team at Resident #198 care plan meeting. Areas were addressed as identified in the grievance. However family continued to come in and find Resident # 198 soaking wet; including her clothes and cushion in her chair. Family indicated that call bell was put on one Sunday and we waited up to 45 minutes to hour for care and treatment for Resident # 198. This is not a great feeling to be waiting so long for someone to answer your call bell and provide the care and treatment. Family stated staffing is a big concern. This family also stated a few weeks ago (wasn't sure of the date) she turned the call light on for Resident #198 and no one came; after 45 minutes or so she had to go out to the hallway and try and get someone. The nurse stated she would try and find a NA to help them. The Family stated they didn't understand why the nurse couldn't just help With Resident #198. The Nursing Assistant (NA) #2 who had been assisgned Resident #198 been terminated. During an interview with the Social Worker on 10/26/2017 at 11:30 AM, SW indicated that Resident #198 family had shared concerns about staff not answering the call bell. SW indicated that the NA #2 had been terminated of because of the incident with Resident #198 and several others. During an interview with Director of Nursing	F 241	until educated. This education will also be added on new hires orientation process for all new nursing employees effective 11/22/2017. MONITORING PROCESS Effective 11/22/2017, Executive Director, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Director of Social Services (#1 or #2), will complete the random audit of call light response for five rooms to determine the call light response time. Executive Director, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Director of Social Services (#1 or #2), will activate the call bell in resident's room/bathroom and observe and document response time. Findings from this monitoring process will be documented on a "Call light response audit form" maintained in the facility compliance binder." This monitoring process will take place daily (Monday through Friday) for 2 weeks then 3x/week for two more weeks, then weekly for 2 weeks then monthly for 3 months or until the pattern of compliance is maintained. Effective 11/22/2017, Executive Director, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Director of Social Services (#1 or #2), will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until the pattern of compliance is	

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F 241	Continued From page 15 (DON) on 10/26/17 at 4:30PM he indicated that his expectation were for all staff to answer call bell within 3-5 minutes. His expectation would be that all staff treat residents with respect and dignity all at times and provide care and treatment.	F 241	maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. RESPONSIBLE PARTY Effective 11/22/2017, the center Executive Director and the Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	

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F 241	Continued From page 16	F 241		
F 242 SS=D	SELF-DETERMINATION - RIGHT TO MAKE CHOICES CFR(s): 483.10(f)(1)-(3) (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews the facility failed to honor a resident's choice to go back to bed (Resident #133) and failed to honor a resident's choice to get out of bed early (Resident #162) for 2 of 3 residents reviewed for choices. Findings included: 1. Resident #133 was admitted to the facility February 19, 2016 with diagnoses of hypertension, diabetes, muscle weakness and restless leg syndrome. Resident #133's Minimum Data Set (MDS) dated October 25, 2017 revealed that she was	F 242	F242D ROOT CAUSE This alleged noncompliance was resulted from the facility staff failed to honor resident's choices to go to bed and waking up in the morning. This was also resulted from facility failure to divide assignments according to acuity level to meet residents' need. IMMEDIATE ACTION TAKEN Resident #133 is no longer in the facility, resident was discharged on 11/10/2017. No other actions taken for this resident. Resident #162 is getting out of bed in the	11/22/17

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F 242	Continued From page 17 cognitively intact and able to make her needs known to staff. Resident #133 needed extensive to total assistance from staff for the completion of all her activities of daily living except for eating. Resident #133 was always incontinent of bladder and bowel. An observation of Resident #133 on October 22, 2017 at 7:15 PM revealed she was sitting beside her bed with her call bell on. An observation on October 22, 2017 at 7:45 PM revealed Resident #133's call bell remained on and she was sitting by the door. During an interview with Resident #133 on October 22, 2017 at 7:47 PM she stated she had been waiting since 6:30 PM to be put to bed. Resident #133 revealed that she put her call bell on around 7:00 PM and the staff cut it off. She added the staff told her they would be back in a few minutes to put her to bed. Resident #133 stated "That was over an hour age and I'm tired and ready to go to bed." During an interview with Nursing Assistant (NA) #4, on October 22, 2017 at 8 PM she revealed that she cut off Resident #133 call bell off around 7 PM and told her she would be back to put her to bed. NA #4 also indicated that she had to wait to get help to put Resident #133 to bed because she was two person assist. NA #4 indicated that she was still waiting on someone to help her put Resident #133 back to bed. Observation of Resident #133 on October 22, 2017 at 8:15 PM revealed she was being put to bed. During an interview with Resident #133 on	F 242	morning per choice effective 10/22/2017. IDENTIFICATION OF OTHERS 100% choices and preferences audit completed by the Director of Social Services #1 and/or Director of Social Services #2 on 11/15/2017, 11/16/2017, & 11/17/2017 to determine each residents choices and preferences, specifically in relation to waking up in the morning and going to bed at night. This audit was completed by interviewing the facility current alert and oriented residents. Each resident's voiced choices and preferences related to preferences on waking up in the morning and going to bed at night was added in each resident's care plan and anticipated effective 11/17/2017. Findings of this audit are documented on "Resident Choices Audit tool" located in the facility compliance binder. SYSTEMIC CHANGES Effective 11/22/2017, moving forward all current nursing assistants will be responsible to honor resident's choices of waking up in the morning and going to bed at night during their shift and as appropriate. Effective 11/22/17, Resident choices and preferences to include choices of waking up in the morning and going to bed at night will be assessed on admission/readmission, quarterly and with significant changes. This assessment will be documented in Choices and	

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F 242	Continued From page 18 October 22, 2017 at 8:25 PM she stated the staff was always short and you had to wait 30 minutes or more to be put to bed especially on the weekend. During an interview with Director of Nursing (DON) on October 25, 2017 at 4:30 PM he indicated that no resident should have to wait an hour and 45 minutes to be put to bed and that each resident's choice should be honored. 2. Resident #162 was admitted on 11/10/16 and diagnoses included chronic obstructive pulmonary disease, cellulitus of the right lower limb, sepsis, muscle weakness and difficulty in walking. A care plan dated 11/23/16 for Resident #162 identified that he required total assistance with his activities of daily living (ADL's) related to weakness and immobility. Interventions included bathe, groom, wash hair and other ADL"s as needed. Assist with oral care daily and as needed. A quarterly Minimum Data Set (MDS) dated 7/24/17 for Resident #162 identified that his cognition was intact. He required extensive two person assist for transfers and extensive one person assist for dressing and personal hygiene. An interview with Resident #162 on 10/25/17 at 2:30 pm revealed that he liked to eat breakfast in the main dining room and that approximately once a week he was not gotten up in time to do this. He stated he had been given different reasons why he could not be up and ready every day so he could eat breakfast in the dining room and that the reasons were usually something to	F 242	Preference tool by the Director of Social Services #1 or #2, and/or Activities Director. Any choices and preferences identified during assessment will be implemented as indicated. Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Coordinators, and/or Director of Social Services #1 or #2, will complete 100% education for all current nursing staff to include licensed nurses and certified nurse aides, to include full time, part time and as needed nursing employees about resident's rights to make choices. The emphasis of this education was on the importance of honoring each resident choices and preferences specifically about resident choices on when to get up in the morning, and when to go back to bed. Any nursing staff not educated by 11/22/2017 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new nursing employees effective 11/22/2017. MONITORING PROCESS Effective 11/22/2017 the Director of Nursing, Assistant Director of Nursing, Director of Social Services #1 and/or Director of Social Services #2 shall ensure compliance by completing the Self Determination Audit form weekly and as needed for 30 days and monthly thereafter to ensure compliance with Self Determination policy and procedure. Any identified discrepancies shall be remediated.	

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F 242	Continued From page 19 do with staffing. Resident #162 added that he had shared this with the facility staff but it was still occurring. A review of the grievance log for the past 6 months, provided by the Administrator, identified one grievance for Resident #162. The grievance was dated 6/20/17 and stated the resident had voiced he was not gotten up and ready as early as he would like sometimes in the mornings. The resident stated that on 6/19/17 he had to get himself ready after a staff member brought him everything he needed as he was tired of waiting for someone to come and assist him. An interview on 10/26/17 at 10:53 am with Nursing Assistant (NA #1) revealed she was familiar with Resident #162 and had provided care for him. She stated that it was the resident's preference to be up, fully dressed and ready to go to the dining room for breakfast. NA #1 stated that Resident #162 had expressed to her that occasionally he wasn't gotten up and dressed in time to eat his breakfast in the dining room. She added that the staff should know that was his preference for getting up. An interview on 10/26/17 at 11:50 am with the Administrator revealed she was familiar with resident. She stated that Resident #162 had mentioned to her that there had been a delay in him getting up and not being able to eat his breakfast in the dining room. The Administrator added the staff was aware of his preference to be up early and it was her expectation that he be up and ready to have breakfast in the dining room.	F 242	Effective 11/22/2017, Executive Director, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Director of Social Services (#1 or #2), will review the completion, and follow through of Choices and Preference tool. Findings from this monitoring process will be documented on a “Choices and Preferences completion audit form” maintained in the facility compliance binder.” This monitoring process will take place daily (Monday through Friday) for 2 weeks then 3x/week for two more weeks, then weekly for 2 weeks then monthly for 3 months or until the pattern of compliance is maintained. Effective 11/22/2017, Executive Director, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Director of Social Services (#1 or #2), will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. RESPONSIBLE PARTY Effective 11/22/2017, the center Executive Director and the Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial	

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F 242	Continued From page 20	F 242	compliance. Compliance Date: 11/22/2017	
F 253 SS=D	HOUSEKEEPING & MAINTENANCE SERVICES CFR(s): 483.10(i)(2) (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to maintain commode seat, wall cove molding, lighting and walls in good repair. The facility failed to maintain clean floors in resident room and bathrooms. This was evident in 2 of 3 resident care units. (Unit 300 and 400) Findings included: A.1. Observation on 10/23/17 at 3:16 PM revealed the wall behind 307 A was damaged. 2. Observation on 10/24/17 at 4 PM revealed in Room #414 the bathroom toilet seat was partially secured to the commode. 3. Observation at 4:05 PM on 10/24/17 revealed a dried brown colored on the back side of the toilet seat in Room #317. 4.Observation on 10/24/17 at 3:45 PM revealed in Room #416 there was an exposed piece of metal on the toilet seat. 5. Observation on 10/24/17 at 3:57 PM revealed in Room 415B an unfinished plaster exposed wall that was rough with black colored marks. 6. Observation on 10/24/17 at 3:45 PM revealed there was peeling paint on the walls in Room #416. 7. Observation on 10/24/17 at 5:25 PM revealed	F 253	F253D ROOT CAUSE This alleged noncompliance was resulted from the facility staff failed to communicate house keeping, laundry and maintenance needs in the facility. This was also resulted from facility failure to have a functional systemic process of communicating maintenance needs. IMMEDIATE ACTION TAKEN A1. On 10/27/2017, a wall behind room #307A was repaired by the facility Maintenance Director and/or Assistant Maintenance Director. A2. On 10/27/2017, the bathroom toiled seat in room #414 was re-secured to the commode by the facility Maintenance Director and/or Assistant Maintenance Director. A3. On 10/30/2017, a dried brown colored on the back side of the toiled seat in room #317 was cleaned by the Housekeeping Supervisor. A4. On 10/30/2017, an exposed piece of metal on the toilet seat in room #416 was removed and replaced by the facility	11/22/17

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F 253	Continued From page 21 the cove molding was missing from the wall behind the head of the bed in room 102 B. B 1. Observations on 10/23/17 at 12:11 PM revealed spider webs above the overbed light and the wall over the bed in Room 318 A. 2. Observation on 10/24/17 at 3:45 PM revealed in Room #416 A there was an accumulation of the dried brown colored in the corners of the floor. There was an accumulation of a brown colored substance in the floor corners of the bathroom. 3. Observation on 10/24/17 at 3:57 PM revealed in Room 415B the privacy curtain had multiple dried brown colored stains. 4. Observation on 10/24/17 at 4 PM revealed in Room #414 there was an accumulation of a dried brown colored substance in the corner of the wall near the window. 5. Observation on 10/24/17 at 4:05 PM revealed the bathroom wall in Room #317 had an approximate 3-inch-wide black colored line across the width of the wall. 6. Observation on 10/25/2017 4:53:31 PM of room 305 revealed an accumulation of dust and brown colored particles in the corners of the floor and under the floor mat. Interview on 10/26/17 at 10:42 AM with Housekeeper (HK) #2 revealed she had not done the cleaning over the light above the bed where the cobwebs were noted because the resident was always in the bed. HK #2 indicated she was not responsible for the floors and that there was a floor tech working twice a week. Unable to interview the floor tech. Interview on 10/26/17 at 1:15 PM with the Director of HK and Laundry. The Director of HK and Laundry indicated expectation of the staff was daily clean resident rooms.	F 253	Maintenance Director and/or Assistant Maintenance Director. A5. On 10/30/2017, un-finished plaster exposed wall that was rough with black colored marks in room #415B was repaired and re-painted by the facility Maintenance Director and/or Assistant Maintenance Director. A6. On 10/31/2017, peeling paint on the walls in room #416 identified and repainted by the facility Maintenance Director and/or Assistant Maintenance Director. A6. On 10/31/2017, the missing cove molding on the wall behind the head of the bed in room #102B was replaced by the facility Maintenance Director and/or Assistant Maintenance Director. B1. On 10/27/2017, the spider webs above the overbred light and the wall over the bed in room #318A was cleaned by the Housekeeping Supervisor. B2. On 10/27/2017, the accumulation of the dried brown colored substances in the corners of the floor, and in the floor corners of the bathroom in room #416 were cleaned by the Housekeeping Supervisor. B3. On 10/27/2017, the privacy curtain with multiple dried brown colored stained in room #415B was removed to be cleaned and replaced by the Housekeeping Supervisor. B4. On 10/27/2017, the accumulation of the dried brown colored substance in the corners of the wall near the window in room #414 was cleaned by the Housekeeping Supervisor. B5. On 10/31/2017, the black colored line	

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F 253	Continued From page 22 Interview on 10/26/2017 at 4:54PM with the Administrator revealed she expected her staff to keep the rooms in good repair and clean. Additionally, the administrator stated the facility conducted a mock survey in July 2016 and the completion date was 8/11/17 to correct housekeeping and maintenance problems identified. Further interview with the administrator revealed she expected privacy curtains to be clean.	F 253	across the width of the wall, approximately 3 inches-wide in room #317 was repainted by the facility Maintenance Director and/or Assistant Maintenance Director. B6. On 10/27/2017, the accumulation of dust and brown colored particles in the corners of the floor and under the floor mat in room #305 was cleaned by the Housekeeping Supervisor. IDENTIFICATION OF OTHERS 100% audits of all resident rooms in the facility conducted by the Maintenance supervisor, assistant maintenance supervisor and/or House Keeping Supervisor to identify any other resident room with the following areas of concerns; Findings of this audit is documented on "Maintenance and Housekeeping audit tool" located in the facility compliance binder. Correction of identified items will be rectified by the Housekeeping Supervisor, Maintenance Director and/or Assistant Maintenance Director by 11/22/2017. Any resident area identified with concerns and not rectified by 11/22/2017 will be removed from resident care usage until rectified. 1. Damaged walls; four other rooms identified with damaged walls. Maintenance supervisor and/or assistant maintenance supervisor schedule the repair of the damaged walls identified. This repair will be completed by 11/22/2017. 2. Bathroom toilet seat not secured; No other room identified with the bathroom	

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F 253	Continued From page 23	F 253	toiled seat being unsecured. No further action taken by Maintenance supervisor and/or assistant maintenance supervisor for this item. 3. Housekeeping needs, specifically brown colored substances/particles, spider webs, and/or uncleaned privacy curtain; five other rooms and/or bathrooms identified with brown colored substances/particles, no other room identified with spider web, three other privacy curtain needed to be cleaned. Housekeeping Supervisor initiated cleaning of those identified brown colored substances/particles and the privacy curtains. The cleaning will be completed by 11/22/2017. 4. Exposed piece of metal; No other resident care are identified with an exposed piece of metal. No further action taken by Maintenance supervisor and/or assistant maintenance supervisor for this item. 5. Cove molding, peeling paints, unfinished plaster 2 other rooms identified to be in need of cove molding, 7 rooms identified with peeling paints, and one room identified with unfinished plaster. Maintenance supervisor and/or assistant maintenance supervisor schedule all identified to be repaired started on 10/30/2017 and to be completed by 11/22/2017. Any room not repaired by 11/22/2017 will be removed out of service until repaired.	

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F 253	Continued From page 24	F 253	SYSTEMIC CHANGES Effective 11/22/2017 a maintenance work book will be placed at each nursing station where any maintenance issue(s) can be recorded by any staff member. Maintenance supervisor or assistant maintenance supervisor will check these books daily (Monday to Friday). Any maintenance needs on the week-end that requires immediate attention, a maintenance supervisor or assistant maintenance supervisor will be contacted by staff on duty. Effective 11/22/2017 House Keeping/Laundry Supervisor re-established a cleaning assignment for housekeeping staff on duty to ensure each resident room is cleaned and sanitized in a daily basis. House Keeping staff will communicate with licensed nurse on duty to aide moving the resident when needed in order to clean resident's room. This will be done while honoring resident's choices. Effective 11/22/2017, revised deep cleaning schedule put forth by the house keeping/Laundry supervisor for each room to be deep cleaned once monthly, By the Housekeeping staff. 100% of active facility employees will be re-educated on the maintenance request log and Procedure to request any maintenance needs by Maintenance Director, and or Executive Director. This education will be completed by 11/22/2017, any staff not educated by 11/22/2017 will not be allowed to work	

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F 253	Continued From page 25	F 253	until educated. This education was also added to new hire process for all new employees effective 11/22/17 and will be provided annually. House Keeping Supervisor and/or Executive Director, will complete 100% education for all current housekeeping and laundry employees to include full time, part time and as needed employees about cleaning procedures. The emphasis of this education was on cleaning of floors and surfaces, corners, dusting, cleaning spider webs and cleaning of any dried substances. Likewise, housekeeping staff were educated on inspecting privacy curtain for cleanliness and report to the supervisor immediately if a privacy curtain is unclean. Any House Keeping and/or Laundry employee not educated by 11/22/2017 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new housekeeping and laundry employees effective 11/22/2017. MONITORING PROCESS Effective 11/22/17, Executive Director and/or Maintenance Director will review maintenance work books to ensure compliance with work orders. This review will be completed weekly x 4 weeks, then monthly x 3 months or until the pattern of compliance is maintained. Findings of this monitoring process will be reported to facility quality assurance and performance improvement committee by the Executive Director and/or Maintenance Director monthly x 3 months or until pattern of	

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F 253	Continued From page 26	F 253	compliance is achieved. This plan will be modified according to outcomes as needed and determined by QAPI committee. Effective 11/22/17 Housekeeping supervisor will complete environmental cleanliness audits weekly x 4 weeks, then monthly x 3 months to assure floors, privacy curtain and surfaces are cleaned properly. Findings of this monitoring process will be reported to facility quality assurance and performance improvement committee by the Executive Director and/or Housekeeping Supervisor monthly x 3 months or until pattern of compliance is achieved. This plan will be modified according to outcomes as needed and determined by QAPI committee. RESPONSIBLE PARTY Effective 11/22/2017, the center Executive Director, Director of Nursing, Maintenance Director and/or House Keeping supervisor will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance. Compliance Date: 11/22/2017	
F 278 SS=D	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED CFR(s): 483.20(g)-(j) (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.	F 278		11/22/17

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F 278	Continued From page 27 (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observations, staff, resident and family interviews and record reviews the facility failed to accurately code the Minimum Data Set (MDS) for wandering behavior (Resident #198) and for level of assistance needed with eating (Resident #88) for 2 of 4 residents reviewed for Activities of Daily Living (ADL's).	F 278	F278 ROOT CAUSE MDS nurse #1, MDS nurse #2, and the facility Director of Social Services #1 and #2 met with the MDS consultant from the contracted facility management and consulting company on 10/25/2017 to	

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F 278	Continued From page 28 Findings Included: 1. Resident #198 was admitted to the facility on 7/24/17 and diagnoses included cerebral vascular accident, hemiplegia and cognitive deficit. A care plan for Resident #198 dated 9/17/17 revealed the resident wandered into unsafe situations. Interventions included to place the resident in an area where frequent observation was possible, alert staff to my wandering behavior, provide diversional activities for me. If I wander away from unit instruct staff to stay with me, converse and gently persuade me to walk back to designated area with them. Note which exits I favor for elopement from the facility and alert staff working near those areas. Monitor and document my behavior. A quarterly minimum data set (MDS) dated 9/18/17 for Resident #198 identified her cognition was moderately impaired and no behaviors of wandering were present during the 7 day look back period. A review of a nursing note dated 9/10/17 at 1:18 pm for Resident #198 stated the resident was observed sitting on the floor in room 202 by a NA. A review of a nursing note dated 9/15/17 at 6:19 pm stated resident does ambulate around the facility in her wheelchair going in and out of other resident's rooms. A review of a nursing note dated 9/18/17 at 6:18 pm for Resident #198 stated she had been found in an empty resident room at the side of the bed on the floor. When resident was asked what she	F 278	review this alleged noncompliance and to identify the root cause. The root cause analysis concluded that, the MDS nurse #2 failed to assess and code resident #88 ADL assistance care needs correctly per RAI guidelines before coding section G of MDS. The analysis further revealed that MDS nurse #2 solely coded section G of resident #88 assessment using documentation completed by facility certified nursing assistants and did not physically assess the resident before coding. Likewise it was identified that Social worker #2 did not code the behaviors documented in Electronic Medication Administration and/or in the nurses notes due to unawareness of how to pull such records and misunderstanding of the look back period for section E of MDS. It is evident that the resident #198 wandering behaviors and resident #88 assistance with eating were anticipated as the plan of care reflect appropriate intervention to address behaviors and ADL. This determination was made on 10/25/17. IMMEDIATE ACTION TAKEN The MDS assessment for resident #198 ARD 9/18/2017 was modified on 10/25/2017 to reflect documented behaviors for wandering on the look back period per RAI guidelines in section E of MDS by Social worker #2 the modified MDS assessment was transmitted and accepted on 10/25/2017 by MDS nurse #1. The MDS assessment for resident #88,	

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F 278	Continued From page 29 was doing she stated she was trying to get in the bed. An interview on 10/26/17 at 1:03 pm with MDS Nurse #1 and Social Worker #2 revealed that Social Worker #2 had completed section E (behaviors) for the MDS dated 9/18/17 for Resident #198. Social Worker #2 stated he believed the look-back period for section E was 14 days. He added that after reviewing the nursing note entries for 9/10, 9/15 and 9/18 section E should have been coded to the positive for wandering behavior. MDS Nurse #1 stated that when she signed the MDS as the coordinator it was to confirm the MDS was not complete, not accurate. She added that section E of the 9/18/17 MDS for Resident #198 should have coded to reflect her wandering behavior during the look back period. An interview on 10/26/17 at 1:15 pm with the Administrator revealed it was her expectation that MDS's were coded accurately and the MDS coordinator should review each section to ensure it was accurate before it was submitted. 2. Resident # 88 was admitted to the facility on 6-15-2017. Resident remains in the facility. Resident #88 was admitted with multiple diagnoses that included acute chronic respiratory failure, chronic obstructive pulmonary disease, muscle weakness, cognitive communication deficit. A review of the MDS dated 6-22-2017 revealed that the resident was cognitively intact. Resident #88 was documented as needing extensive assistance with one person for bed mobility,	F 278	ARD 6/22/2017, section G assistance of daily living (ADL) was modified on 11/21/2017 to reflect the correct assistance needed by resident during meals specifically eating. The modification was done by MDS nurse #1. The modified/corrected MDS assessment was transmitted and accepted on 11/21/2017. The MDS assessment for resident #88, ARD 9/21/2017, section G assistance of daily living (ADL) was modified on 11/21/2017 to reflect the correct assistance needed by resident during meals specifically eating. The modification was done by MDS nurse #1. The modified/corrected MDS assessment was transmitted and accepted on 11/21/2017. IDENTIFICATION OF OTHERS 100% audit for current residents' most recent MDS assessment was completed by the Social Worker #1 and #2, MDS Coordinator, MDS Coordinator #2 and/or MDS coordinator #3 to determine if any other resident with documented wandering behaviors in the look back period was coded appropriately per RAI guidelines in section E of MDS 3.0, and to identify if any other resident has in-accurate coding of eating in section G of MDS 3.0. The results of the audit indicated no other residents with documented wandering behaviors identified to be coded inaccurately per RAI guidelines in section E of MDS 3.0, and, no other resident coded inaccurately per	

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F 278	Continued From page 30 extensive assistance with 2 people for transfers, extensive assistance with one person for locomotion, dressing, personal hygiene and toileting. Resident #88 was documented as needing supervision with set up help only for eating. A review of the MDS dated 9-21-17 revealed that the resident was not cognitively intact. Resident #88 was documented as needing limited assistance with one person for bed mobility, extensive assistance with 2 people for transfers, independent with locomotion, extensive assistance with one person for dressing and toileting, limited assistance with one person for personal hygiene and eating. A review of the care plan dated 9-22-17 revealed the following goal; the resident will continue to receive needed and required activity of daily living (ADL) care and assistance daily. The interventions for resident #88 included staff assisting with bathing and dressing routinely, assist with grooming and oral care, assist with toileting and transfers using 2 people and assist with wheelchair mobility. A review of the physician orders dated 9-11-17 revealed that physical therapy was ordered to treat for range of motion, mobility, gait training and therapeutic exercise. A review of the nursing notes dated 6-16-17 revealed that resident #88 could feed himself and required one person assist with toileting and ADL's. A review of the nursing notes dated 6-17-17 revealed that resident #88 could feed himself and	F 278	RAI guidelines in section E and G of MDS 3.0 respectively. Findings of this audit is documented on "MDS accuracy audit tool" located in the facility compliance binder. This audit was completed on 10/29/17. SYSTEMIC CHANGES Effective 11/22/2017, social workers (#1 and/or #2) will review behaviors documented in Clinical documentation and electronic Medication Administration Records (eMARs) through "clinical notes report" and "behavior types" report located in the facility used licensed Electronic Health records software to ensure all documented behaviors from eMAR on a look back period are coded accurately per RAI guidelines. On 10/25/17, MDS consultant conducted re-education to MDS nurse #1, MDS nurse #2, Director of Social Services #1 and #2, on accurate coding of MDS using Resident Assessment Instruments (RAI) guidelines. This education covers coding requirements and supportive documentation for each item coded in MDS, specifically related to section E and Section G of MDS 3.0 assessment. Effective 11/22/2017, Education on the Accurate coding of MDS will be added to new hires orientation education for MDS nurses, Director of Social Services, Activities Director, and the C Dietary Manager (DM). This education will also be provided annually for MDS nurses, Director of Social Services, Activities Director, and the Dietary Manager (CDM).	

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F 278	Continued From page 31 required one person assist with ADL's and transfers. A review of the nursing notes dated 6-20-17 revealed that resident #88 was independent with his bed mobility and wheelchair mobility but required a one person assist with ADL's. A review of the documentation in resident #88's medical record from 6-21-17 to 10-26-17 revealed there was no more documentation related to what type of assistance the resident was receiving in regards to his ADL's, feeding and mobility. An observation of resident #88 occurred on 10-25-17 at 5:15pm. Resident #88 was observed wheeling himself to the dining room to eat supper. The resident was also observed being able to pick up his own glass from the table and take a drink without assistance. Once supper arrived the resident was able to eat his meal on his own without assistance from staff. An interview with the nurse occurred on 10-26-17 at 3:30pm. The nurse stated that resident #88 takes himself to the dining room to eat but the nurse had not had any reports of resident #88 not being able to feed himself. An interview with the MDS coordinator occurred on 10-26-17 at 3:40pm. The MDS coordinator stated she did not know why resident #88 was documented as having a decline in eating because she did not have any notes. The MDS coordinator then looked at the nursing notes and stated "it might be because he had a room change and was diagnosed with a urinary tract infection."	F 278	MONITORING PROCESS Effective 11/22/2017, prior to submission, MDS Nurse #1 and/or MDS nurse #2 will review section E of MDS assessment completed by the social worker #1 or 2 to ensure that all documented behaviors on clinical records and eMARs are coded accurately per RAI guideline. These reviews will take place Monday through Friday, prior to submission for 2 weeks on all completed MDS assessments, 50% of all completed MDS assessments weekly for 2 weeks, then 25% of all completed MDS assessments monthly for 3 months or until the pattern of compliance is achieved. Any inaccurate coding identifies will be noted and corrected before submission by MDS nurse #1 or #2. Findings of this monitoring process will be documented on MDS accuracy monitoring tool located in the facility compliance binder. Effective 11/22/2017, prior to submission, MDS Nurse #1 will review section G of MDS 3.0 completed by MDS nurse #2 (and vice versa) to ensure that an appropriate self-care performance level and assistance needed for eating component of ADL is codded accurately per RAI guideline. These reviews will take place Monday through Friday, prior to submission for 2 weeks on all completed MDS assessments, 50% of all completed MDS assessments weekly for 2 weeks, then 25% of all completed MDS assessments monthly for 3 months or until the pattern of compliance is achieved. Any inaccurate coding identifies	

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F 278	Continued From page 32 An interview with resident #88 and his wife occurred on 10-26-17 at 4:00pm. Resident #88 stated he has not needed help from staff to eat any of his meals. The resident's wife agreed with same. The wife stated sometimes she will stay with him during meal time but that she has not had to help him with his meal. An interview with the Administrator occurred on 10-26-17 at 1:15pm. The Administrator stated that her expectation would be that the MDS be coded correctly and that the MDS coordinator should have reviewed staff's documentation to ensure that the MDS was coded correctly.	F 278	will be noted and corrected before submission by MDS nurse #1 or #2 (whoever is completing the audit). Findings of this monitoring process will be documented on MDS accuracy monitoring tool located in the facility compliance binder. Effective 11/22/2017, MDS nurse #1 or #2, Director of Social Services #1, and/or Director of Social services #2 will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly X3 months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. RESPONSIBLE PARTY Effective 11/22/2017, the center Executive Director and the Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance. Compliance Date: 11/22/2017.	
F 353 SS=E	SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS CFR(s): 483.35(a)(1)-(4) 483.35 Nursing Services The facility must have sufficient nursing staff with	F 353		11/22/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING _____ B. WING _____	C 10/26/2017

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F 353	Continued From page 33	F 353		

the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).
[As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)]

(a) Sufficient Staff.
(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

(i) Except when waived under paragraph (e) of this section, licensed nurses; and

(ii) Other nursing personnel, including but not limited to nurse aides.

(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

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F 353	Continued From page 34 (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, family interviews, staff interviews and record review the facility failed to provide nursing staffing of sufficient quantity and quality to provide the required assistance with putting a resident to bed when requested, to get a resident up when requested and to provide care in a manner to maintain dignity by not answering call bells timely for residents needing assistance with activities of daily living. This was evident for 2 of 3 residents reviewed for choices (Resident #133 and Resident #198) and 3 of 3 residents reviewed for dignity. (Resident #126 Resident #133, and Resident # 162). Findings included: This tag is cross referenced to: F-241 Based on observations, resident, family and staff interview the facility failed to provide care in a manner to maintain the resident's dignity by not answering call bells timely for resident needing assistance with activities of daily living (Resident #133 and Resident # 198) and by allowing a resident to set in a wet brief for 5 hour (Resident #126). This was evident by 3 of 3 residents reviewed for dignity. F-242 Based on observation, staff and resident interviews the facility failed to honor a resident's choice to go back to bed (Resident #133) and failed to honor a resident's choice to get out of	F 353	ROOT CAUSE F241-This alleged noncompliance was resulted from the facility staff failed to answer call bell in a timely manner and attend to the resident's need. This was also resulted from facility failure to divide assignments according to acuity level to meet residents' need, which make a facility appeared to have insufficient number of staff. F252-This alleged noncompliance was resulted from the facility staff failed to honor resident's choices to go to bed and waking up in the morning. This was also resulted from facility failure to divide assignments according to acuity level to meet residents' need, which make a facility appeared to have insufficient number of staff. IMMEDIATE ACTION TAKEN Resident #133 is no longer in the facility, resident was discharged on 11/10/2017. No other actions taken for this resident. Resident #126 is no longer in the facility, resident was discharged on 10/29/2017. No other actions taken for this resident. On 10/25/2017 Resident #198 incontinent care was provided by Nurse Aide #6 and Nurse Aide #7. Resident #162 is getting out of bed in the morning per choice effective 10/22/2017.	

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F 353	Continued From page 35 bed early (Resident #162) for 2 of 3 residents reviewed for choices. During an interview with Nursing Assistant (NA) #4, on October 22, 2017 at 8 PM she revealed that she cut off Resident #133 call bell off around 7 PM and told her she would be back to put her to bed. NA #4 also indicated that she had to wait to get staff to put Resident #133 to bed because she was two person assist. NA #4 indicated that she was still waiting on help to for Resident #133. A review of the grievance log for the past 6 months, provided by the Administrator, identified one grievance for Resident #162. The grievance was dated June 20, 20177 and stated the resident had voiced he was not gotten up and ready as early as he would like sometimes in the mornings. The resident stated that on June 19, 2017 he had to get himself ready after a staff member brought him everything he needed as he was tired of waiting for someone to come and assist him. An interview on October 26, 2017 at 10:53 AM with Nursing Assistant (NA #1) revealed she was familiar with Resident #162 and had provided care for him. She stated that it was the resident's preference to be up, fully dressed and ready to go to the dining room for breakfast. NA #1 stated that Resident #162 had expressed to her that occasionally he wasn't gotten up and dressed in time to eat his breakfast in the dining room. She added that the staff should know that was his preference for getting up. During an interview with Director of Nursing (DON) on October 26, 2017 at 4:30 PM he indicated that his expectation were for all staff to	F 353	IDENTIFICATION OF OTHERS On 11/20/2017, 100% of all current alert and oriented residents in the facility were interviewed by the Center Executive Director, Director of Social services (#1 or #2), Director of Nursing, Assistant Director of Nursing and/or Staff Development Coordinator to determine if any other resident voiced concerns about call bell responses. Six other residents complained of call bell not being answered in a timely manner. 100% choices and preferences audit completed by the Director of Social Services #1 and/or Director of Social Services #2 on 11/15/2017, 11/16/2017, & 11/17/2017 to determine each residents choices and preferences, specifically in relation to waking up in the morning and going to bed at night. This audit was completed by interviewing the facility current alert and oriented residents. Each resident's voiced choices and preferences related to preferences on waking up in the morning and going to bed at night was added in each resident's care plan and anticipated effective 11/17/2017. Findings of this audit are documented on "Resident Choices Audit tool" located in the facility compliance binder. 100% audit of all grievances filed by residents or family members within the last 30 days completed by the Executive director, Director of Social Services #1 and/or Director of Social Services #2 to determine any grievance that involve resident being wet for extended period of time and determine whether or not such	

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F 353	Continued From page 36 answer call bell within 3-5 minutes. DON also indicated no residents sure had to wait 5 hours for care and treatment. Zero tolerated for this. His expectation would be that all staff treat residents with respect and dignity all at times and that resident's choice needs to be honored. On October 26, 2017 at 4:29 PM during an interview with the Administrator. She stated that the facility was currently addressing sufficient staffing, call bell response and the dining experience. She stated that they are trying to recruit new staff and provide all of the new staff with training that focuses on "Residents have a voice and a choice". Stated that the department managers include this in their daily Ambassador rounds they do on their assigned units.	F 353	grievances were investigated and/or resolved per center's grievance policy and procedures. The audit revealed that all other grievances related to incontinent care and call bell responses filed within the last 30 days were investigated and resolved per facility grievance policy and procedure. This audit will be completed by 11/22/17. Findings of this audit will be documented on grievance audit tool located at the facility compliance binder. On 11/20/2017, the Center Executive Director, Director of Social services (#1 or #2), Director of Nursing, Assistant Director of Nursing and/or Staff Development Coordinator conducted the 100% observation of all current residents in the facility to determine if any other resident has any sign or indication of being soiled (with urine). The observation revealed that no other resident identified to be soiled (with urine). Findings of this audit will be documented on "resident observation tool" located at the facility compliance binder. SYSTEMIC CHANGES Effective 11/22/2017, Resident #198 is being toileted per plan of care and has not evidenced unmet needs related to call light response. On 11/20/2017, the Regional Clinical Consultant revised facility nursing assistant assignment to ensure that the staffing pattern corresponds with the acuity level Effective 11/22/2017, the facility will utilize the revised assignment sheet and ensure that each assignment's acuity level is	

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F 353	Continued From page 37	F 353	maintained. The Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator and/or Unit Coordinators will adjust the assignment sheets whenever necessary to ensure that the acuity level is maintained effective 11/22/2017. Effective 11/22/2017, moving forward all current nursing assistants will be responsible to honor resident's choices of waking up in the morning and going to bed at night during their shift and as appropriate. Effective 11/22/17, Resident choices and preferences to include choices of waking up in the morning and going to bed at night will be assessed on admission/readmission, quarterly and with significant changes. This assessment will be documented in Choices and Preference tool by the Director of Social Services #1 or #2, and/or Activities Director. Any choices and preferences identified during assessment will be implemented as indicated. Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator and/or Unit Coordinators will complete 100% education for all current facility employees, to include full time, part time and as needed employees about call bell responses. The emphasis of this education was on the importance of responding to resident's call bell when activated and ensure resident's needs are anticipated. Any employee not educated by 11/22/2017 will not be allowed to work until educated. This education will also be added on new hires orientation process	

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F 353	Continued From page 38	F 353	for all new employees effective 11/22/2017. Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator and/or Unit Coordinators will complete 100% education for all current nursing staff to include licensed nurses and certified nurse aides, to include full time, part time and as needed nursing employees about incontinent care. The emphasis of this education was on the importance of providing incontinent care for each resident in a timely fashion and ensure resident's needs are anticipated. Any nursing staff not educated by 11/22/2017 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new nursing employees effective 11/22/2017. Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Coordinators, and/or Director of Social Services #1 or #2, will complete 100% education for all current nursing staff to include licensed nurses and certified nurse aides, to include full time, part time and as needed nursing employees about resident's rights to make choices. The emphasis of this education was on the importance of honoring each resident choices and preferences specifically about resident choices on when to get up in the morning, and when to go back to bed. Any nursing staff not educated by 11/22/2017 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new nursing	

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F 353	Continued From page 39	F 353	employees effective 11/22/2017. MONITORING PROCESS Effective 11/22/2017, Executive Director, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Director of Social Services (#1 or #2), will complete the random audit of call light response for five rooms to determine the call light response time. Executive Director, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Director of Social Services (#1 or #2), will activate the call bell in resident's room/bathroom and observe and document response time. Findings from this monitoring process will be documented on a "Call light response audit form" maintained in the facility compliance binder." This monitoring process will take place daily (Monday through Friday) for 2 weeks then 3x/week for two more weeks, then weekly for 2 weeks then monthly for 3 months or until the pattern of compliance is maintained. Effective 11/22/2017 the Director of Nursing, Assistant Director of Nursing, Director of Social Services #1 and/or Director of Social Services #2 shall ensure compliance by completing the Self Determination Audit form weekly and as needed for 30 days and monthly thereafter to ensure compliance with Self Determination policy and procedure. Any identified discrepancies shall be remediated. Effective 11/22/2017, Executive Director, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator,	

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F 353	Continued From page 40	F 353	Director of Social Services (#1 or #2), will review the completion, and follow through of Choices and Preference tool. Findings from this monitoring process will be documented on a “Choices and Preferences completion audit form” maintained in the facility compliance binder.” This monitoring process will take place daily (Monday through Friday) for 2 weeks then 3x/week for two more weeks, then weekly for 2 weeks then monthly for 3 months or until the pattern of compliance is maintained. Effective 11/22/2017, Executive Director, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Director of Social Services (#1 or #2), will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Effective 11/22/2017, Executive Director, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Director of Social Services (#1 or #2), will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.	

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F 353	Continued From page 41	F 353	RESPONSIBLE PARTY Effective 11/22/2017, the center Executive Director and the Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance and has sufficient nursing staff to meet each resident's need and in accordance with the facility assessment. Compliance Date: 11/22/2017	
F 356 SS=B	POSTED NURSE STAFFING INFORMATION CFR(s): 483.35(g)(1)-(4) 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census.	F 356		11/22/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 356	Continued From page 42 (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to post daily nurse staffing information during one (1) of five (5) days; and the facility failed to post the correct resident census on the daily nurse staffing information for three (3) of four (5) days during the recertification survey. Finding included: An observation on 10/22/2017 at 7:30 PM revealed the daily nurse staffing information for 10/20/2017 was posted in a plastic see-through cover on a stand on top of a desk in the facility's	F 356	F356 ROOT CAUSE This alleged noncompliance was resulted from lack of systemic method necessary to ensure nursing hours are posted with correct information daily to include Saturdays and Sunday. The analysis also reveal that this alleged noncompliance resulted from the Center's Director of Nursing misinterpretation of regulatory requirements related to posting of nursing hours, specifically of whether or not residents on bed hold should be counted. The Director of Nursing thought residents	

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F 356	Continued From page 43 front lobby. The staffing information was not posted for 10/22/2017. An observation on 10/23/2017 at 10 AM revealed daily nurse staffing information was posted in a plastic see-through cover on a stand on top of a desk in the facility's front lobby and was dated 10/23/2017. The facility's census sheet revealed there were 115 census on 10/23/17. The nursing staff posted included all census in the facility, and including the 3 bed holds. An observation on 10/24/2017 at 11 AM revealed the daily nurse staffing information was posted in a plastic see-through cover on a stand on top of a desk in the facility's front lobby and was dated 10/24/2017. The facility's resident census sheet revealed there were 118 census. The census number on the posting continued to combine bed holds census with the skilled nursing census. The correct census was 116. An interview with the Director of Nursing on 10/24/2017 at 11:30AM revealed that the census was 116 on 10/24/2017. He stated that it was his expectation that posted nurse staffing be correct and not combine bed holds home census.	F 356	on bed hold can be counted on nursing hours since they are counted on daily census of the facility. Regional Clinical Consultant re-educated the Center Director of Nursing on 10/26/2017 correct information that should be posted per regulatory requirements and procedures and the importance of completing thorough investigation. This analysis was completed on 10/26/2017 IMMEDIATE ACTION TAKEN No residents were affected by this alleged deficient practice On 10/23/2017, and 10/24/2017 posted daily nurse staffing information retrieved by the Director of Nursing, Corrected and re-posted with the correct census information. SYSTEMIC CHANGES Effective 11/22/2017, Staffing Coordinator, Director of Nursing, Assistant Director of Nursing and/or Staff Development coordinator will complete daily posting of nursing hours, and post such information on the day before it's due, Monday through Friday. Receptionist on duty, Nurse Managers and or 100 hall nurse will modify posting at the beginning of each shift to reflect the correct information to include correct census, number of full time equivalents and total hours scheduled to work per shift for Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and Certified Nurse Aides, as well as removing the previous day posting from the board. The posted hours will be located on the facility front lobby for easy	

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F 356	Continued From page 44	F 356	accessibility and visibility. Effective 11/22/2017, Staffing Coordinator, Director of Nursing, Assistant Director of Nursing and/or Staff Development coordinator will complete daily posting of nursing hours, for Saturdays, Sundays and Mondays and post such information by the close of business on Fridays. Receptionist on duty, Week-end supervisor and or 100 hall nurse will modify posting at the beginning of each shift on Saturday and Sundays to reflect the correct information to include correct census, number of full time equivalents and total hours scheduled to work per shift for Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and Certified Nurse Aides, as well as removing the previous day posting from the board. The posted hours will be located on the facility front lobby for easy accessibility and visibility. Executive Director, Director of Nursing (DON), Assistant Director of Nursing (ADON) and/or Staff Development Coordinator (SDC) will complete 100% education for all current facility Licensed nurses, receptionist and Staffing coordinator, to include full time, part time and as needed employees about revised process of posting nursing hours to ensure compliance. The emphasis of this education was on the importance of including only residents in the facility at the beginning of each shift and nursing staffing responsible for direct care present at the beginning of each shift. Any	

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	345529	A. BUILDING _____ B. WING _____	C 10/26/2017

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F 356	Continued From page 45	F 356	Licensed nurse, Receptionist and/or Staffing coordinator not educated by 11/22/2017 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new employees effective 11/22/2017. MONITORING PROCESS Effective 11/22/2017, Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator will review and audit posted nursing staffing information daily (Monday through Friday) to ensure completion and accuracy. This monitoring process will take place daily (Monday through Friday) for 2 weeks then 3x/week for two more weeks, then weekly for 2 weeks then monthly for 3 months or until the pattern of compliance is maintained. Any issues identified during this monitoring process will be addressed promptly. Findings from this monitoring process will be documented on a “Daily staffing audit” form and filed in the facility compliance binder effective 11/22/2017. Effective 11/22/2017, Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.	

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F 356	Continued From page 46	F 356	RESPONSIBLE PARTY Effective 11/22/2017, the center Executive Director and the Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance. Compliance Date: 11/22/2017.	
F 431 SS=D	DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS CFR(s): 483.45(b)(2)(3)(g)(h) The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and	F 431		11/22/17

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F 431	Continued From page 47 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 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews and staff interviews the facility failed to store medications in an upright position per the manufactures instructions for 1of 2 medication carts observed. Findings included: Review of the manufacturer's instructions for storage of Prednisolone eye drop container revealed the bottle must be stored upright.	F 431	F431 ROOT CAUSE This alleged non compliance resulted from the facility failure to have a system of ensuring medication that should be stored upright remains upright when the cart is moved. This is concluded as such medication to include eye drops were stored in the plastic back without a wide base to support upright placement.	

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F 431	Continued From page 48 Review of the manufacturer's instructions for storage of Calcitonin Salmon spray container revealed the bottle must be stored upright. A.Observation of the 100-medication cart on 10/24/17 at 5:34 PM revealed 1. Two (2) Prednisolone eye drop containers were not stored upright. The label on the bottles indicated to store upright. 2. Calcitonin Salmon spray was not stored upright. The label on the medication indicated to stand the medication upright. Interview on 10/25/2017 at 1:45 PM with the consultant pharmacist revealed that medications should be stored upright. B.1. Observation of the 100-medication cart on 10/25/2017 at 2:15 PM with the Director of Nurses (DON)and consultant pharmacist revealed the Prednisolone eye drop containers and Calcitonin Salmon nasal spray still were not stored upright. 2. Continued observation with the DON revealed in the Unit 1 medication refrigerator was a stored vial of Novolog regular insulin in which the orange cap had been removed and was not dated when opened. Expectations should be stored upright. Interview on 10/25/2017at 4:19 PM with Administrator revealed her expectation would be for staff to follow the label instructions on how to store and follow the instructions.	F 431	Likewise, the facility failed to date an insulin placed in the refrigerator when an orange top fell off. IMMEDIATE ACTION TAKEN No Residents were named in this alleged non compliance A1. Two identified Prednisolone eye drop in a container not stored upright in 100-medication cart were discarded and re-ordered by the Pharmacy Clinical Director on 10/25/2017. A2. One identified Calcitonin Salmon spray not stored upright in 100-medication cart were discarded and re-ordered by the Pharmacy Clinical Director on 10/25/2017. B2. The opened Novolog regular insulin bottle observed in the Unit 1 medication refrigerator was discarded and re-ordered Pharmacy Clinical Director on 10/25/2017. IDENTIFICATION OF OTHERS All residents who receives medication have the potential to be affected by this alleged non- compliance. On 10/25/17 and 10/26/2917, the Pharmacy Clinical Director, Pharmacy Consultant and/or Director of Nursing, inspected all medication storage rooms and medication carts to ensure all medication are stored per manufacturer guidelines. The audit revealed that all other medication were stored per manufacturer guidelines and all insulin were dated per manufacturer guidelines. Findings of this audit is documented on “Medication storage audit tool” located at	

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F 431	Continued From page 49	F 431	the facility compliance binder. SYSTEMIC CHANGES Effective 11/22/2017, all medication that needs to be stored upright will be placed in prescription bottles to help maintaining such upright especially when medication carts are moved. Effective 11/22/2017, an incoming nurse will review the medication cart to ensure Prednisolone eye drop and/or Calcitonin Salmon spray are stored upright. Any identified deviation will be corrected promptly. Effective 11/22/2017, any open insulin will be dated and stored per manufacturer recommendation Director of Nursing (DON), Assistant Director of Nursing (ADON) and/or Staff Development Coordinator (SDC) will complete 100% education for all current facility Licensed nurses, and Medication aide, to include full time, part time and as needed employees about revised process of medication storage and dating of insulin. The emphasis of this education was on the importance of ensuring that medication that is recommended to be kept upright will need to be placed in the prescription bottles while stored in medication carts. This education will be completed by 11/22/2017, Any Licensed nurse, and/or Medication aide not educated by 11/22/2017 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new Licensed employees effective 11/22/2017.	

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F 431	Continued From page 50	F 431	MONITORING PROCESS The Director of Nursing, Assistant Director of Nursing, and/or Nursing Supervisor will be responsible for checking medication carts and medication to ensure medication are stored and labelled appropriately per manufacturer guidelines. This monitoring process will take place daily (Monday through Friday) for 2 weeks then, then weekly for 2 weeks then monthly for 3 months or until the pattern of compliance is maintained. Any issues identified during this monitoring process will be addressed promptly. Findings from this monitoring process will be documented on a “Medication Storage Monitoring tools” and filed in the facility compliance binder effective 11/22/2017. Effective 11/22/2017, Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. RESPONSIBLE PARTY Effective 11/22/2017, the center Executive Director and the Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure	

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F 431	Continued From page 51	F 431	the facility remains in substantial compliance. Compliance Date: 11/22/2017.	
F 469 SS=D	MAINTAINS EFFECTIVE PEST CONTROL PROGRAM CFR(s): 483.90(i)(4) (i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews the facility failed to have an effective pest control program. This was evident in 1 of 3 resident care units. Findings included: Observation on 10/26/17 at 10:27 AM revealed a dead insect on the bathroom floor in Room #201. Observation on 10/26/17 at 10:30 AM revealed a dead black colored insect laying on the floor in the hallway near unit 200. Interview on 10/26/17 at 10:35 AM with Housekeeper (HK) #1 revealed she was a new employee and has never seen any pest in the facility. Observation on 10/26/17 at 10:40 AM revealed 3 black colored insect crawling in the hallway off the 200-resident unit. Interview on 10/26/17 at 10:42 AM with HK #3 indicated that she had seen 2 (two) or 3 (three) crawling insects in the hallway but never reported. Interview on 10/26/2017 at 3:58 PM with the Maintenance Director who stated that the pest control company provided routine service to the facility every 3rd Tuesday of each month. He stated that a concern log is kept at the front desk should a resident, staff or family member had a	F 469	F469 ROOT CAUSE Based on root cause analysis by facility administrative staff, facility staff failed to report the sighting of insects as directed/expected. However the facility does have a Pest Control Program as required by regulation. IMMEDIATE ACTION Room 201 and the entire 200 hall were inspected on 11/15/2017 for any pest activity by Contracted licensed Pest control company, no further issues identified. On November 15, 2017 Licensed Pest Control company that provides services at the center did a complete pest audit, including full facility treatment inside and outside around perimeter of facility. IDENTIFICATION OF OTHERS On November 15, 2017 Licensed Pest Control company that provides services at	11/22/17

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F 469	Continued From page 52 concern regarding bugs. Continued interview revealed his expectation was that staff members would report any pest concerns to the receptionist so these areas would be treated during the monthly visit. Interview on 10/26/2017 at 4:54 PM with the administrator revealed she expected staff to report seeing insects in the facility.	F 469	the center did a complete pest audit, including full facility treatment inside and outside around perimeter of facility. No other issues related to pest control identified. SYSTEMIC CHANGES Effective 11/22/2017, the center Director of Maintenance, Director of Housekeeping and/or Executive Director, initiated a process for communication by facility employees by creating Maintenance Books at each nurse station, and revised the pest control book at receptionist desk. Those books will be utilized by facility staff to communicate all maintenance requests and/or any pest noted in the facility that need attention. The center Director of Housekeeping, and/or Maintenance Director will review the maintenance and pest control books daily (Monday through Friday) and address any identified maintenance and/or pest control related issue promptly effective 11/22/2017. Any negative findings will be documented on the pest control audit forms and maintained in the “Daily meeting binder”. This systemic process will take place daily (Monday through Friday). Any identified issues will be addressed promptly and appropriate actions will be implemented by the center Director of Social services #1, Director of Social services #2 and/or Executive Director. This process will be incorporated in a daily Stand up meeting. Director of Maintenance, Director of	

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F 469	Continued From page 53	F 469	Housekeeping and/or Executive Director, Director of Nursing (DON), Assistant Director of Nursing (ADON) and/or Staff Development Coordinator (SDC) will complete 100% education for all current facility employees, to include full time, part time and as needed employees on reporting any noted pests in the facility promptly in Maintenance Book at nurse station, and/or pest control book at receptionist desk. The emphasis of this education was on the importance of communicating any noted pest in the facility. This education will be completed by 11/22/2017, any employee not educated by 11/22/2017 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new employees effective 11/22/2017. MONITORING PROCESS Effective 11/22/2017, Executive director, and/or Director of Nursing will monitor compliance by reviewing maintenance binders and Pest Control book to ensure compliance on both usage by facility staff and to ensure that the Maintenance Director and/or the Director of House Keeping review the books daily (Monday through Friday). This monitoring process will take place weekly for four weeks, then monthly for three more months or until the pattern of compliance is maintained. Any issues identified during this monitoring process will be addressed promptly. Findings from this monitoring process will be documented on a “pest Control Review” form and filed in the facility	

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F 469	Continued From page 54	F 469	compliance binder effective 11/22/2017. Effective 11/22/2017, Maintenance Director, Housekeeping Director, and/or the Center Executive director, will monitor compliance by completing Pest Control audit by inspecting the facility for any evidence of any pests. This monitoring process will take place three times a week for four weeks, then weekly for eight more weeks, then monthly for 3 months or until the pattern of compliance is maintained. Any issues identified during this monitoring process will be addressed promptly. Findings from this monitoring process will be documented on a “pest Control Audit” form and filed in the facility compliance binder effective 11/22/2017. Effective 11/22/2017, Maintenance Director, Housekeeping Director, and/or the Center Executive director will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until the pattern of compliance is maintained. The QAPI committee will modify this plan to ensure the facility attain and maintain substantial compliance. RESPONSIBLE PARTY Effective 11/22/2017, the center Executive Director and the Director of Maintenance and/or Housekeeping Supervisor will be ultimately responsible to ensure	

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F 469	Continued From page 55	F 469	implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance. Compliance Date: 11/22/2017	
F 520 SS=D	QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS CFR(s): 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) (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		11/22/17

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F 520	Continued From page 56 Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility's Quality Assessment and Assurance Committee failed to maintain procedures and monitor the interventions that the committee put into place in August 2016. This was for a deficiency that was originally cited in quality of care on a recertification and complaint survey on August 25, 2016. This was for five recite deficiencies in the area: Dignity and Respect F241, Choices F242, Minimum Date Set (MDS coding F 278, Provide Sufficient Nursing Staff F 353 and Dating Opened Biological Medication F 431. This deficiencies was cited again on October 26, 2017 during recertification and a complaint survey. The continued failure of the facility during two surveys showed a pattern of the facility's inability to sustain an effective Quality Assurance (QAA) Program. Findings included: This tag is cross referred to: F 241 Based on record review, observation and interview, the facility allowed residents to sit and wait to be fed in the assisted dining room while other residents were being fed for 3 (Residents #	F 520	F520 ROOT CAUSE Repeated citation caused by the facility failure to follow through with plan of action set forth on the previous two surveys. F241 -This alleged noncompliance was resulted from the facility staff failed to answer call bell in a timely manner and attend to the resident's need. This was also resulted from facility failure to divide assignments according to acuity level to meet residents' need, which make a facility appeared to have insufficient number of staff. F242 -This alleged noncompliance was resulted from the facility staff failed to honor resident's choices to go to bed and waking up in the morning. This was also resulted from facility failure to divide assignments according to acuity level to meet residents' need, which make a facility appeared to have insufficient number of staff. F278 - MDS nurse #1, MDS nurse #2, and the facility Director of Social Services #1 and #2 met with the MDS consultant from the contracted facility management and	

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UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616

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F 520	Continued From page 57 26, # 94 & # 81) of 3 sampled residents observed during a lunch meal. During the recertification and complaint survey of October 26, 2017 the facility was cited for F241 falling to provide care in a manner to maintain the resident's dignity by not answering call bells timely for resident needing assistance with activities of daily living (Resident #133 and Resident # 198) and by allowing a resident to set in a wet brief for 5 hours. (Resident #126). This was evident by 3 of 3 residents reviewed for dignity. F242 Based on staff interview, resident interview and record review the facility failed to honor a resident ' s choice to ambulate daily for 1 of 1 sampled residents able to ambulate with assistance (Resident # 22). During the recertification and complaint survey of October 26,2017 the facility was cited for F242 falling to honor a resident's choice to go back to bed (Resident #133) and failed to honor a resident's choice to get out of bed early (Resident #162) for 2 of 3 residents reviewed for choices. F 278 Based on resident interview, staff interview, observation, and medical record review, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of life expectancy (Resident #1), hospice care (Resident #1), respite care (Resident #1), active diagnoses (Residents #1 and #11), medications (Residents #11 and #72), behaviors (Resident #103), dental status (Resident #1), and preferences for customary and routine activities (Resident #96) for 5 of 26 sampled residents.	F 520	consulting company on 10/25/2017 to review this alleged noncompliance and to identify the root cause. The root cause analysis concluded that, the MDS nurse #2 failed to assess and code resident #88 ADL assistance care needs correctly per RAI guidelines before coding section G of MDS. The analysis further revealed that MDS nurse #2 solely coded section G of resident #88 assessment using documentation completed by facility certified nursing assistants and did not physically assess the resident before coding. Likewise it was identified that Social worker #2 did not code the behaviors documented in Electronic Medication Administration and/or in the nurses notes due to unawareness of how to pull such records and misunderstanding of the look back period for section E of MDS. It is evident that the resident #198 wandering behaviors and resident #88 assistance with eating were anticipated as the plan of care reflect appropriate intervention to address behaviors and ADL. This determination was made on 10/25/17. IMMEDIATE ACTION TAKEN Resident #133 is no longer in the facility, resident was discharged on 11/10/2017. No other actions taken for this resident. Resident #126 is no longer in the facility, resident was discharged on 10/29/2017. No other actions taken for this resident. On 10/25/2017 Resident #198 incontinent care was provided by Nurse Aide #6 and Nurse Aide #7. Resident #162 is getting out of bed in the	

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F 520	Continued From page 58 During the recertification and complaint survey of October 26, 217 the facility was cited for F278 falling to accurately code the Minimum Data Set (MDS) for wandering behavior (Resident #198) and for level of assistance needed with eating (Resident #88) for 2 of 4 residents reviewed for Activities of Daily Living (ADL's). F 353 Based on record review, observation and staff, family and resident interviews, the facility failed to provide sufficient number of direct care nursing staff to meet the needs of residents as evidenced by allowing residents to sit and wait to be fed in the assisted dining room while other residents were being fed, for 3 (Residents # 26, # 94 & # 81) of 3 sampled residents observed,, failing to honor a resident ' s choice to ambulate daily for 1 of 1 sampled residents able to ambulate with assistance (Resident # 22), not resolving grievances about resident ' s getting help in a timely manner, and failing to shave a male resident while providing activities of daily living care to 1 of 1 sampled male residents reviewed for activities of daily living (Resident # 22). During the recertification and complaint survey of October 26, 2017 the facility was cited for F353 falling to provide nursing staffing of sufficient quantity and quality to provide the required assistance with putting a resident to bed when requested, to get a resident up when requested and to provide care in a manner to maintain dignity by not answering call bells timely for residents needing assistance with activities of daily living. This was evident for 2 of 3 residents reviewed for choices (Resident #133 and Resident #198) and 3 of 3 residents reviewed for dignity. (Resident #126 Resident #133, and	F 520	morning per choice effective 10/22/2017. The MDS assessment for resident #198 ARD 9/18/2017 was modified on 10/25/2017 to reflect documented behaviors for wandering on the look back period per RAI guidelines in section E of MDS by Social worker #2 the modified MDS assessment was transmitted and accepted on 10/25/2017 by MDS nurse #1. The MDS assessment for resident #88, ARD 6/22/2017, section G assistance of daily living (ADL) was modified on 11/21/2017 to reflect the correct assistance needed by resident during meals specifically eating. The modification was done by MDS nurse #1. The modified/corrected MDS assessment was transmitted and accepted on 11/21/2017. The MDS assessment for resident #88, ARD 9/21/2017, section G assistance of daily living (ADL) was modified on 11/21/2017 to reflect the correct assistance needed by resident during meals specifically eating. The modification was done by MDS nurse #1. The modified/corrected MDS assessment was transmitted and accepted on 11/21/2017. A1. Two identified Prednisolone eye drop in a container not stored upright in 100-medication cart were discarded and re-ordered by the Pharmacy Clinical Director on 11/25/2017. A2. One identified Calcitonin Salmon spray not stored upright in 100-medication cart were discarded and re-ordered by the Pharmacy Clinical Director on 11/25/2017.	

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F 520	Continued From page 59 Resident # 162). F431 Based on record review, observation and interview, the facility failed to discard expired medications in 1 (400/500 medication room) of 2 medication rooms and to date a medication in 1 (400 medication cart) of 4 medication carts. During the recertification and complaint survey of October 26, 2017 the facility was cited for F 431 falling to store medications in an upright position per the manufactures instructions for 1of 2 medication carts observed. F 520 Based on medical record review, observation, staff, resident and family interview, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions the committee put into place following the 9/25/14 and 9/17/15 recertification surveys. This was for the recited deficiencies in the areas of Dignity (F241), and Activities of Daily Living (F312) cited 9/25/14 and 9/17/15 and in the areas of Assessment Accuracy (F278), Comprehensive Care Plans (F280), Sufficient Staffing (F353) and Sanitary Conditions (F371) cited 9/17/15. These deficiencies were cited again on the recertification survey of 8/25/16. The continued failure of the facility during three consecutive federal surveys of record (F241, F312) and two consecutive federal surveys of record (F278, F280, F353 and F371) shows a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance program. During the recertification and complaint survey of October 26, 2017 the facility was cited for F520 for falling to follow the facility's Quality Assessment and Assurance Committee failed to maintain procedures and monitor the	F 520	B2. The opened Novolog regular insulin bottle observed in the Unit 1 medication refrigerator was discarded and re-ordered Pharmacy Clinical Director on 11/25/2017. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: IDENTIFICATION OF OTHERS On 11/20/2017, 100% of all current alert and oriented residents in the facility were interviewed by the Center Executive Director, Director of Social services (#1 or #2), Director of Nursing, Assistant Director of Nursing and/or Staff Development Coordinator to determine if any other resident voiced concerns about call bell responses. Six other residents complained of call bell not being answered in a timely manner. 100% choices and preferences audit completed by the Director of Social Services #1 and/or Director of Social Services #2 on 11/15/2017, 11/16/2017, & 11/17/2017 to determine each residents choices and preferences, specifically in relation to waking up in the morning and going to bed at night. This audit was completed by interviewing the facility current alert and oriented residents. Each resident's voiced choices and preferences related to preferences on waking up in the morning and going to bed at night was added in each resident's care plan and anticipated effective 11/17/2017. Findings of this audit are documented on "Resident Choices Audit tool" located in the facility compliance binder. 100% audit of all grievances filed by	

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F 520	Continued From page 60 interventions that the committee put into place in August 2016. This was for a deficiency that was originally cited in quality of care on a recertification and complaint survey on August 25, 2016. This was for five recite deficiencies in the area: Dignity and Respect F241, Choices F242, Minimum Date Set (MDS coding F 278, Provide Sufficient Nursing Staff F 353 and Dating Opened Biological Medication F 431. This deficiencies was cited again on October 26, 2017 during recertification and a complaint survey. The continued failure of the facility during two surveys showed a pattern of the facility's inability to sustain an effective Quality Assurance (QAA) Program. On October 26, 2017 at 4:29 PM during an interview with the Administrator. She stated that the facility was currently addressing sufficient staffing, call bell response and the dining experience. She stated that they are trying to recruit new staff and provide all of the new staff with training that focuses on "Residents have a voice and a choice". Stated that the department managers include this in their daily Ambassador rounds they do on their assigned units. Stated that they are working on assessment accuracy and they are conducting informal audits of the residents, documentation and MDS accuracy. Stated that she receives monthly audits from the pharmacy consultant regarding the med carts and med rooms and nursing also does	F 520	residents or family members within the last 30 days completed by the Executive director, Director of Social Services #1 and/or Director of Social Services #2 to determine any grievance that involve resident being wet for extended period of time and determine whether or not such grievances were investigated and/or resolved per center's grievance policy and procedures. The audit revealed that all other grievances related to incontinent care and call bell responses filed within the last 30 days were investigated and resolved per facility grievance policy and procedure. This audit will be completed by 11/22/17. Findings of this audit will be documented on grievance audit tool located at the facility compliance binder. On 11/20/2017, the Center Executive Director, Director of Social services (#1 or #2), Director of Nursing, Assistant Director of Nursing and/or Staff Development Coordinator conducted the 100% observation of all current residents in the facility to determine if any other resident has any sign or indication of being soiled (with urine). The observation revealed that no other resident identified to be soiled (with urine). Findings of this audit will be documented on "resident observation tool" located at the facility compliance binder. 100% audit for current residents' most recent MDS assessment was completed by the Social Worker #1 and #2, MDS Coordinator, MDS Coordinator #2 and/or MDS coordinator #3 to determine if any other resident with documented wandering behaviors in the look back	

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F 520	Continued From page 61	F 520	period was coded appropriately per RAI guidelines in section E of MDS 3.0, and to identify if any other resident has in-accurate coding of eating in section G of MDS 3.0. The results of the audit indicated no other residents with documented wandering behaviors identified to be coded inaccurately per RAI guidelines in section E of MDS 3.0, and, no other resident coded inaccurately per RAI guidelines in section E and G of MDS 3.0 respectively. Findings of this audit is documented on "MDS accuracy audit tool" located in the facility compliance binder. This audit was completed on 10/29/17. On 10/25/17 and 10/26/2917, the Pharmacy Clinical Director, Pharmacy Consultant and/or Director of Nursing, inspected all medication storage rooms and medication carts to ensure all medication are stored per manufacturer guidelines. The audit revealed that all other medication were stored per manufacturer guidelines and all insulin were dated per manufacturer guidelines. Findings of this audit is documented on "Medication storage audit tool" located at the facility compliance binder. SYSTEMIC CHANGES On 11/20/2017, the Regional Clinical Consultant will complete re-training with the facility Administrator and the Director of Nursing, regarding the quality assurance performance improvement program (QAPI) process. This education will include how to identify quality deficiencies as well as ways to establish a system that will ensure consistent and	

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F 520	Continued From page 62	F 520	measurable outcomes. The education will also cover methods on how to track and trend data, as well as best practices on root cause analysis. Effective 11/22/2017, this plan of correction will be incorporated and discussed in the QAPI committees meeting by the Executive Director monthly until the next annual inspection. Any repeated citation in the following year will necessitate modification of this plan and extension of discussion during monthly QAPI meetings. Effective 11/22/2017, Resident #198 is being toileted per plan of care and has not evidenced unmet needs related to call light response. On 11/20/2017, the Regional Clinical Consultant revised facility nursing assistant assignment to ensure that the staffing pattern corresponds with the acuity level Effective 11/22/2017, the facility will utilize the revised assignment sheet and ensure that each assignment's acuity level is maintained. The Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator and/or Unit Coordinators will adjust the assignment sheets whenever necessary to ensure that the acuity level is maintained effective 11/22/2017. Effective 11/22/2017, moving forward all current nursing assistants will be responsible to honor resident's choices of waking up in the morning and going to bed at night during their shift and as appropriate. Effective 11/22/17, Resident choices and	

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F 520	Continued From page 63	F 520	preferences to include choices of waking up in the morning and going to bed at night will be assessed on admission/readmission, quarterly and with significant changes. This assessment will be documented in Choices and Preference tool by the Director of Social Services #1 or #2, and/or Activities Director. Any choices and preferences identified during assessment will be implemented as indicated. Effective 11/22/2017, social workers (#1 and/or #2) will review behaviors documented in Clinical documentation and electronic Medication Administration Records (eMARs) through “clinical notes report” and “behavior types” report located in the facility used licensed Electronic Health records software to ensure all documented behaviors from eMAR on a look back period are coded accurately per RAI guidelines. Effective 11/22/2017, all medication that needs to be stored upright will be placed in prescription bottles to help maintaining such upright especially when medication carts are moved. Effective 11/22/2017, an incoming nurse will review the medication cart to ensure Prednisolone eye drop and/or Calcitonin Salmon spray are stored upright. Any identified deviation will be corrected promptly. Effective 11/22/2017, any open insulin will be dated and stored per manufacturer recommendation Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator and/or Unit Coordinators will complete	

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F 520	Continued From page 64	F 520	100% education for all current facility employees, to include full time, part time and as needed employees about call bell responses. The emphasis of this education was on the importance of responding to resident's call bell when activated and ensure resident's needs are anticipated. Any employee not educated by 11/22/2017 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new employees effective 11/22/2017. Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator and/or Unit Coordinators will complete 100% education for all current nursing staff to include licensed nurses and certified nurse aides, to include full time, part time and as needed nursing employees about incontinent care. The emphasis of this education was on the importance of providing incontinent care for each resident in a timely fashion and ensure resident's needs are anticipated. Any nursing staff not educated by 11/22/2017 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new nursing employees effective 11/22/2017. Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Coordinators, and/or Director of Social Services #1 or #2, will complete 100% education for all current nursing staff to include licensed nurses and certified nurse aides, to include full time, part time and as needed nursing	

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F 520	Continued From page 65	F 520	employees about resident's rights to make choices. The emphasis of this education was on the importance of honoring each resident choices and preferences specifically about resident choices on when to get up in the morning, and when to go back to bed. Any nursing staff not educated by 11/22/2017 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new nursing employees effective 11/22/2017. On 10/25/17, MDS consultant conducted re-education to MDS nurse #1, MDS nurse #2, Director of Social Services #1 and #2, on accurate coding of MDS using Resident Assessment Instruments (RAI) guidelines. This education covers coding requirements and supportive documentation for each item coded in MDS, specifically related to section E and Section G of MDS 3.0 assessment. Effective 11/22/2017, Education on the Accurate coding of MDS will be added to new hires orientation education for MDS nurses, Director of Social Services, Activities Director, and the C Dietary Manager (DM). This education will also be provided annually for MDS nurses, Director of Social Services, Activities Director, and the Dietary Manager (CDM). Director of Nursing (DON), Assistant Director of Nursing (ADON) and/or Staff Development Coordinator (SDC) will complete 100% education for all current facility Licensed nurses, and Medication aide, to include full time, part time and as needed employees about revised process of medication storage and dating of	

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F 520	Continued From page 66	F 520	insulin. The emphasis of this education was on the importance of ensuring that medication that is recommended to be kept upright will need to be placed in the prescription bottles while stored in medication carts. This education will be completed by 11/22/2017, Any Licensed nurse, and/or Medication aide not educated by 11/22/2017 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new Licensed employees effective 11/22/2017. MONITORING PROCESS Effective 11/22/2017, Executive Director, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Director of Social Services (#1 or #2), will complete the random audit of call light response for five rooms to determine the call light response time. Executive Director, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Director of Social Services (#1 or #2), will activate the call bell in resident's room/bathroom and observe and document response time. Findings from this monitoring process will be documented on a "Call light response audit form" maintained in the facility compliance binder." This monitoring process will take place daily (Monday through Friday) for 2 weeks then 3x/week for two more weeks, then weekly for 2 weeks then monthly for 3 months or until the pattern of compliance is maintained. Effective 11/22/2017 the Director of	

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F 520	Continued From page 67	F 520	Nursing, Assistant Director of Nursing, Director of Social Services #1 and/or Director of Social Services #2 shall ensure compliance by completing the Self Determination Audit form weekly and as needed for 30 days and monthly thereafter to ensure compliance with Self Determination policy and procedure. Any identified discrepancies shall be remediated. Effective 11/22/2017, Executive Director, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Director of Social Services (#1 or #2), will review the completion, and follow through of Choices and Preference tool. Findings from this monitoring process will be documented on a “Choices and Preferences completion audit form” maintained in the facility compliance binder.” This monitoring process will take place daily (Monday through Friday) for 2 weeks then 3x/week for two more weeks, then weekly for 2 weeks then monthly for 3 months or until the pattern of compliance is maintained. The Director of Nursing, Assistant Director of Nursing, and/or Nursing Supervisor will be responsible for checking medication carts and medication to ensure medication are stored and labelled appropriately per manufacturer guidelines. This monitoring process will take place daily (Monday through Friday) for 2 weeks then, then weekly for 2 weeks then monthly for 3 months or until the pattern of compliance is maintained. Any issues identified during this monitoring process will be addressed promptly.	

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F 520	Continued From page 68	F 520	Findings from this monitoring process will be documented on a “Medication Storage Monitoring tools” and filed in the facility compliance binder effective 11/22/2017. Effective 11/22/2017, Executive Director, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Director of Social Services (#1 or #2), will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Effective 11/22/2017, prior to submission, MDS Nurse #1 and/or MDS nurse #2 will review section E of MDS assessment completed by the social worker #1 or 2 to ensure that all documented behaviors on clinical records and eMARs are coded accurately per RAI guideline. These reviews will take place Monday through Friday, prior to submission for 2 weeks on all completed MDS assessments, 50% of all completed MDS assessments weekly for 2 weeks, then 25% of all completed MDS assessments monthly for 3 months or until the pattern of compliance is achieved. Any inaccurate coding identifies will be noted and corrected before submission by MDS nurse #1 or #2. Findings of this monitoring process will be documented on MDS accuracy monitoring tool located in the facility compliance binder. Effective 11/22/2017, prior to submission,	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 69	F 520	MDS Nurse #1 will review section G of MDS 3.0 completed by MDS nurse #2 (and vice versa) to ensure that an appropriate self-care performance level and assistance needed for eating component of ADL is codded accurately per RAI guideline. These reviews will take place Monday through Friday, prior to submission for 2 weeks on all completed MDS assessments, 50% of all completed MDS assessments weekly for 2 weeks, then 25% of all completed MDS assessments monthly for 3 months or until the pattern of compliance is achieved. Any inaccurate coding identifies will be noted and corrected before submission by MDS nurse #1 or #2 (whoever is completing the audit). Findings of this monitoring process will be documented on MDS accuracy monitoring tool located in the facility compliance binder. Effective 11/22/2017, Executive Director, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Director of Social Services (#1 or #2), will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Effective 11/22/2017, MDS nurse #1 or #2, Director of Social Services #1, and/or Director of Social services #2 will report findings of this monitoring process to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING _____ B. WING _____	C 10/26/2017

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F 520	Continued From page 70	F 520	facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly X3 months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Effective 11/22/2017, Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. RESPONSIBLE PARTY Effective 11/22/2017, the center Executive Director and the Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance and has sufficient nursing staff to meet each resident's need and in accordance with the facility assessment. Compliance Date: 11/22/2017	