STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345167	A. BUILDING _____ B. WING _____	11/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YADKIN NURSING CARE CENTER	903 W MAIN STREET YADKINVILLE, NC 27055

(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 167 SS=C	RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE CFR(s): 483.10(g)(10)(i)(11) (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, the facility failed to post the notice of location and availability of facility survey results. Findings included:	F 167	F167 Standard Disclaimer: The plan of correction for this alleged deficient practice is provided as a necessary requirement of continued participation in the Medicare and Medicaid	12/1/17

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

Electronically Signed | 12/11/2017

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F 167	Continued From page 1 On 11/13/2017 at 9:40 AM, an observation was made that facility survey results were in a notebook binder in a plastic container attached to the wall in the reading nook area across from Nurse's Station #1. An observation on 11/13/17 at 9:45 AM revealed there was not a notice posted in the facility regarding the availability and location of recent survey results. An interview was completed with the Resident Council president on 11/15/17 at 10:15 AM. During this interview, she stated she did not know where the survey results were posted in the facility. An additional observation on 11/15/17 at 11:05 AM revealed there was not a notice posted in the facility regarding the survey results. An interview was conducted with the Director of Nursing on 11/15/17 at 11:40 AM. During this interview, she stated she thought there was a sign posted for the location of the survey results, but believed it was taken down when the facility was painted a year ago. During an additional interview with the Director of Nursing on 11/15/17 at 11:46 AM, she verified there was no posting in the building of the survey results location.	F 167	program(s) and does not in any manner constitute an admission to the validity of the alleged deficient practice(s). No residents were specifically identified as having been affected by this alleged deficient practice. For those having the potential to be affected by the alleged deficient practice, a notice stating, "Survey Report is Located In the Resident Information Area" has been posted adjacent to the Business Office on November 15, 2017. On December 1, 2017 the Resident Council was notified of the location of the survey report and the Resident Council was both informed and shown the location of the Resident Information Area. To ensure compliance, the Social Worker shall verify the location of and posting of the most recent survey results monthly by completing a Resident Information Area audit. Such audits shall be completed monthly for three months and quarterly thereafter. The results of such audits shall be presented to the Quality Assurance Committee monthly for three months and quarterly thereafter.	
F 248 SS=D	ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES CFR(s): 483.24(c)(1) (c) Activities. (1) The facility must provide, based on the	F 248		12/14/17

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F 248	Continued From page 2 comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and resident and staff interviews, the facility failed to provide the activity preferences of 1 of 1 sampled resident with a hearing impairment and a diagnosis of macular degeneration. (Resident #56) Findings included: Resident #56 was admitted to the facility on 10/6/11 with diagnoses which included: diabetes mellitus and macular degeneration. Review of the annual Minimum Data Set (MDS) dated 8/4/17 indicated Resident #56 was cognitively intact, had moderate difficulty with hearing, no hearing aid, adequate vision, and wore corrective lenses. The MDS also indicated the resident preferred to participate in religious services/practices and to listen to music. The Care Plan dated 11/3/17 revealed Resident #56 had visual impairment related to blindness in her right eye, and has had lens implant in her left eye. Interventions included: provide large print materials if desired; encourage resident to wear her glasses, keep glasses clean/in good repair.	F 248	F248 Standard Disclaimer: The plan of correction for this alleged deficient practice is provided as a necessary requirement of continued participation in the Medicare and Medicaid program(s) and does not in any manner constitute an admission to the validity of the alleged deficient practice(s). The activity preferences for Resident #56 have been updated as of November 22, 2017. Resident #56 was given a CD player and CDs. Resident #56 was also given a large print Bible. For those residents having the potential to be affected by the same alleged deficient practice, the Activity Director and/or their designee have reviewed and/or updated the activity preferences for all current residents in the facility. Similarly, activity preferences shall be updated at the initiation of a care plan for each newly admitted residents, at each care plan review and/or change in condition. Activity	

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F 248	Continued From page 3 The Care Plan dated 11/3/17 revealed Resident #56 did not attend out of room activities and preferred her own activities. Interventions included: Activity Director to discuss/monitor for preferences; Activity staff to provide in room visits with the resident twice each week. Review of the monthly Activity Records for October 2017 and November 2017 indicated Resident #56 received mail delivery 2-3 times per month, attended 1-social event, and was provided an in-room activity 2-3 times each week. A review of the Activity Note dated 11/2/17 documented Resident #56 preferred not to attend out of room activities but the Activity staff visited the resident at least twice each week. There was no available documentation indicating Resident #56's activity preferences (religion, music) were provided. During an observation and interview on 11/13/17 at 11:21a.m., Resident #56 was sitting upright in a geri-chair in the corner, next to the head of her bed. The resident revealed she always sat in her room in that chair from morning to evening, except when staff assisted her to the bathroom. She indicated she did not care to attend the group activities. The resident stated she would like to read her bible but had trouble seeing the print. The resident stated that she had not told anyone, but no one had asked or offered an alternative. She revealed she was mostly blind in her right eye and her left eye was not much better. The resident was noted to have difficulty hearing and revealed she was hard of hearing. Resident #56 stated the small television in the	F 248	staff have been in serviced by the Corporate Nurse Consultant specific to the importance of identifying, communicating, and accommodating/honoring a resident's activity preferences specifically the role of activities personnel in carrying out a resident's care plan. To ensure compliance, the Activity Director shall complete an audit of each current resident's activity preferences to ensure the resident's preferences are 1) documented and 2) there are sufficient activity offerings to accommodate the resident's activity preferences. Such an audit shall be documented on the Resident Activity Audit Form. Subsequent to the initial audit of all current resident's activity preferences, the Activity Director shall re-verify/re-assess each resident's activity preferences at the initiation of a care plan for each newly admitted residents, at each care plan review and/or change in condition. There will be a stand up meeting every morning to address any changes of condition that would require a change in any residents' care plan. The Activity Director shall audit all resident's activity preferences monthly for three months and quarterly upon care plan review for each resident thereafter. Results of the activity preferences audit shall be presented to the Quality Assurance Committee monthly for three months and quarterly thereafter.	

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F 248	Continued From page 4	F 248		

room belonged to her roommate and the volume was too low for her to hear it.

During an observation and interview on 11/15/17 at 1:30p.m., Resident #56 was sitting upright in her geri-chair. There were eyeglasses in a case in a basket on the bed next to the resident's chair. The resident stated that she sometimes wore the eyeglasses. The small television was on but the volume was low and was located near the resident's roommate chair.

During an interview on 11/16/17 at 10:11a.m., the Activity Director stated Resident #56 was considered a "Special Contact" due to the resident refusing to attend out of room activities. She revealed the resident received in-room visits from Activity staff 2-3 times each week which included socialization (the resident enjoyed talking about her family). The Activity Director stated that she had offered to take the resident to the facility's library, bring the resident books or magazines, but the resident refused. The Activity Director revealed she was not aware Resident #56 had a diagnosis of macular degeneration and did not have an understanding of what the disease involved. She stated she was aware the resident was hard of hearing and always ensured she spoke loud enough during conversations with the resident; but she did not know if the resident had hearing aides. The Activity Director acknowledged Resident #56 had informed her that she (the resident) enjoyed religious services/practices/music but she was not able to hear it; and that she would like to be able to read her bible but the print was too small. The Activity Directed revealed the facility had one radio/dvd player which was used in the smaller Activity Room, continuously; but she had not informed the

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F 248	Continued From page 5 resident of this and it was not listed on the Activity Calendar. She also revealed the bibles in the facility's library had small print, but the facility recently obtained more bibles and she would check on the size of the print.	F 248		
F 279 SS=D	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d);483.21(b)(1) 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights	F 279		12/14/17

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F 279	Continued From page 6 under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to develop a care plan for adaptive equipment management and failed to document the review of the Care Area Assessments for behaviors for 2 of 22 sampled residents (Resident #123 and Resident # 61) reviewed for comprehensive care plans. Findings included:	F 279	F279 Standard Disclaimer: The plan of correction for this alleged deficient practice is provided as a necessary requirement of continued participation in the Medicare and Medicaid program(s) and does not in any manner constitute an admission to the validity of	

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F 279	Continued From page 7 1. Resident #123 was admitted to the facility on 7/28/15 with a diagnosis of ID and Aphasia. A record review of the most recent annual Minimum Data Set (MDS) dated 7/14/17 revealed the resident had severely impaired cognition. The resident did not exhibit behaviors and did not refuse care. The resident required extensive assistance with bed mobility, transfers, dressing and toileting, was totally dependent for bathing and hygiene and was non-ambulatory. The resident was able to feed self after set up with supervision. Resident #123 was out of bed to a w/c daily with a tray attached. The tray was put on the resident's wheelchair when he got out of bed in the morning and removed when he went to bed at night. The resident used the tray for meals and liked to look at magazines and point to pictures in them to show staff members. The resident was utilizing the tray while at home and was made by the resident's brother. A record review of the care plans revealed care plans for long term care placement, behaviors, need for social interaction, intellectual disability, aphasia, incontinence, potential for falls, risk for altered nutrition and potential for skin impairment. There were no care plans for use or care of the tray. A record review of the resident plan of care sheets revealed "homemade tabletop to wheelchair". An interview with the PT manager on 11/14/17 at 3:22 PM revealed the resident was assessed by all three therapy disciplines on admission. She	F 279	the alleged deficient practice(s). The Care Plans for Resident #'s 161 and 61 have been updated to reflect those items that were not included in the respective resident's care plan(s). The omission of care planning for adaptive equipment for 2 of 22 sampled residents was a human error and an errant oversight of the Interdisciplinary Care Plan Team to ensure each residents' needs are properly care planned. For those residents having the potential to be affected by the same alleged deficient practice, each member of the Interdisciplinary Care Plan Team has been in serviced by the Corporate Nurse Consultant specific to the purpose and use of the Care Area Assessment (CAA) worksheets. To ensure compliance, the MDS Nurse(s) have completed a 100% audit of all current resident's care plans to ensure the care plans accurately reflect the resident's needs. Such audit(s) have been documented on the Care Plan Audit form which notes 1) the name of the resident reviewed; 2)the date the care plan was reviewed and by whom and 3) what changes/amendments, if any, were made to the resident's care plan. There will be a stand up meeting every morning that the MDS Nurse(s) will attend addressing any changes of condition that would require a change in a residents' care plan. Such audits shall continue monthly for a	

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F 279	Continued From page 8 revealed the therapy department tried removing the tray and implementing other interventions, but the resident would not tolerate it and would become agitated. She further revealed the resident did not try to get out of the wheelchair and the tray was a type of adaptive equipment for the resident that helped him feel safe and helped him communicate with staff. An interview with the resident's brother on 11/14/17 at 3:08 PM revealed that he had been using the tray at home with the resident for about 5 years. He stated the resident ate off of it and liked to look at magazines on it. He stated it was easily removed by pulling it straight up. An interview with a nursing assistant caring for Resident#123 revealed the resident used the tray daily and would remove it at night when he was ready to go to bed. She further revealed housekeeping would clean the try after meals. An interview with the nurse caring for the resident revealed she knew the resident came to the facility with the tray and used it every day. An interview of the MDS nurse on 11/15/17 at approximately 10:30 AM revealed that she didn't care plan the tray because she wouldn't care plan that. An interview with the Director of Nursing on 11/16/17 at approximately 2:15 PM revealed she would expect that something that was such a big part of the resident's daily routine to be care planned. 2. Resident #61 was admitted to the facility on	F 279	period of 3 months and shall continue quarterly thereafter or until such time as the Quality Assurance Committee determines there to be no additional need to continue such audits.	

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F 279	Continued From page 9	F 279		

10/8/15 with diagnoses including dementia without behavioral disturbance.

Review of a significant change Minimum Data Set (MDS) dated 10/13/17 revealed he had problems with long and short term memory, had no behavior of rejection of care, did wander 1 to 3 days and had no change in his behavior. The MDS indicated the resident required extensive assistance of two plus persons for bed mobility, transfer, dressing, toileting and limited assistance with personal hygiene and bathing. He ate independently. The bowel and bladder assessment included he was frequently incontinent of bladder, and always incontinent of bowel. This assessment indicated he had skin tears as a skin condition.

The Care Area Assessments (CAAs) did not indicate a care plan would be developed for the problems of behaviors and ADL decline. Risk factors or contributing factors were not included and the area for referrals was blank.

Review of the care plan dated 10/13/17 included a problem of recent decline in ADL performance and required total care for all ADLs. A problem of decline in behaviors as evidenced by wandering into other resident's rooms, being verbally inappropriate with staff and increased agitation. Approach in a calm manner, document all behaviors in clinical record, provide distraction as needed when demonstrating behaviors, alert staff to wandering behavior, reinforce unacceptability of verbal abuse, there were 7 documented incidences on the care plan of behaviors: 8/19/17 poor safety awareness; 9/12/17 resident urinating on bathroom floor; 9/13/17 urinating on bathroom floor; 9/23/17 resident wandering into other

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F 279	Continued From page 10 resident rooms. became angry when staff redirected verbally inappropriate to staff; 10/9/17 aimless wandering with redirection by staff provided; 10/14/17 verbally inappropriate with staff during adl care; 10/20/17 resident stuffing socks down commode filled with feces. Interview with the MDS nurse revealed she did a summary in the nurse's notes for the care plan. The decision to proceed to care plan was on section V when it said "checked." The MDS nurse did not have evidence the CAA's were reviewed, if a referral would be needed to another discipline and the team decided to proceed to care plan the problems.	F 279		
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items	F 280		12/14/17

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F 280	Continued From page 11 included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident.	F 280		

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F 280	Continued From page 12 (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews and medical record review, the facility failed to update the care plan to reflect documented behaviors and psychotropic medications for 1 of 5 residents (Resident #131) reviewed for unnecessary medications. The facility also failed to update the Care Plans of 1 of 1 sampled resident (Resident #157) reviewed for dialysis and nutrition. Findings included: 1. Resident #131 was admitted to the facility on 4/10/17 and discharged to the hospital on 9/12/17. He re-admitted to the facility on 9/16/17 with diagnoses that included, in part, non-Alzheimer's dementia and depression.	F 280	F280 Standard Disclaimer: The plan of correction for this alleged deficient practice is provided as a necessary requirement of continued participation in the Medicare and Medicaid program(s) and does not in any manner constitute an admission to the validity of the alleged deficient practice(s). The Care Plans for Resident #'s 131 and 157 have been updated to reflect those items that were not included in the respective resident's care plan(s). The omission of care planning for	

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F 280	Continued From page 13 A review of the admission comprehensive Minimum Data Set (MDS) assessment dated 4/17/17 revealed Resident #131 was cognitively intact and had no behaviors but endorsed feeling tired/having little energy. A review of the 14 day MDS assessment dated 9/30/17 revealed Resident #131 had severely impaired cognition, no behaviors, and he endorsed difficulty with sleeping, feeling tired/having little energy and poor appetite. The 14 day MDS further revealed Resident #131 had received antidepressant medication 7 out of 7 days. A review of the current care plan revealed no care plan that addressed psychotropic medications or behaviors. A review of a physician order dated 6/9/17 revealed, "Celexa (an antidepressant medication), 20 milligrams (mg), daily." A review of a physician order dated 6/13/17 revealed, "Depakote (a mood stabilizer medication), 125 mg, twice a day." Further review of physician orders revealed the Depakote was increased on 10/4/17 to 250 mg, twice a day. A review of a physician order dated 10/20/17 revealed, "Ativan (an antianxiety medication), 1 mg, every six hours as needed for agitation; Ativan 1 mg, intramuscular (IM) every six hours as needed for agitation." A review of the October medication administration record revealed Resident #131 received IM Ativan on 10/21/17 at 8:00 AM. A review of a nurse's note dated 11/14/17 at 6:45	F 280	behaviors and psychotropic medications for 1 of 5 residents was human error and an errant oversight of the Interdisciplinary Care Plan Team to ensure each residents exhibiting behaviors and/or using psychotropic medications are care planned sufficiently. Specific to Resident #157, the resident had previously had a venous catheter for access - which had been care planned by the Interdisciplinary Care Plan Team. The omission of the AVF was merely an oversight. Resident #157 was admitted with a Right intrajugular permcath, which is on the care plan. On 10/27/2017 Resident #157 had a left arm fistula placed. The omission of care planning the AVF was simply human error and an errant oversight. For those residents having the potential to be affected by the same alleged deficient practice, each member of the Interdisciplinary Care Plan Team has been in-serviced by the Corporate Nurse Consultant specific to the importance of ensuring a resident's care plan is an accurate reflection of the residents' needs. To ensure compliance, the MDS Nurse(s) have completed a 100% audit of all current resident's care plans to ensure the care plans accurately reflect the resident's needs. Such audit(s) have been documented on the Care Plan Audit form which notes 1) the name of the resident reviewed; 2) the date the care plan was reviewed and by whom and 3) what changes/amendments, if any, were made to the resident's care plan. There will be a stand up meeting every	

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F 280	Continued From page 14 PM revealed, " ...refused blood sugar, smacking and trying to hit, resident yelling ..." A review of a nurse's note dated 11/14/17 at 1:43 PM revealed, "The resident has had a behavioral episode this shift. He has been verbally abusive and combative with care." A review of a nurse's note dated 11/13/17 revealed, "The resident refused to get his finger stick done this shift after several attempts with encouragement. The writer was told to get out of his room and if I did not he would knock me out of it. He was kicking his legs and trying to hit the writer with his fist." A review of a nurse's note dated 11/12/17 revealed, "Resident is easily agitated and frequently is resistant to care and combative at times." A review of a nurse's note dated 11/11/17 revealed, "He was hostile to staff as they attempted to give care. He was yelling and cursing at them and trying to hit them." A review of a nurse's note dated 11/8/17 revealed, " ...Resident is easily agitated and frequently is resistant to care and combative at times." A review of a nurse's note dated 11/1/17 revealed, " ...He became agitated earlier in the shift and refused his blood sugar and 4:30 PM insulin by becoming combative and trying to hit this nurse. He also began yelling out that continued for approximately 30 minutes after episode."	F 280	morning that the MDS Nurse(s) will attend addressing any changes of condition that would require a change in a residents' care plan. Such audits shall continue monthly for a period of 3 months and shall continue quarterly thereafter or until such time as the Quality Assurance Committee determines there to be no additional need to continue such audits.	

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A review of a physician note dated 10/5/17 revealed, " ...Agitation, yelling and generally acting out continue to be an issue."

A review of a care plan note dated 10/6/17 revealed, " ...No behaviors during the 7 day look back period, however, he does continue to exhibit some verbal and physical behavior at times ...Is taking Celexa daily for diagnosis of depression."

A review of a physician note dated 8/18/17 revealed, "Agitation, yelling and generally acting out continue to be an issue. Plan: Dementia with behavioral disturbance. This remains a management challenge."

Further review of the medical record from 4/19/17 through 10/21/17 revealed 35 notes of documented behaviors that included agitation, hitting, cursing, spitting on staff, yelling out, combative, verbally abusive, threatening to hit, resistive to care, hallucinating, throwing objects, disrobing, and slapping.

An interview was completed with MDS Nurse #1 on 11/15/17 at 1:58 PM. She said that typically behaviors and psychotropic medications were care planned. She stated if a resident was having behaviors then it was added to the care plan. MDS Nurse #1 further stated information about a resident's behavior was brought to the inter-disciplinary team meetings that were held each week.

An interview was completed with MDS Nurse #2 on 11/15/17 at 2:21 PM. She stated when a resident had frequent behaviors it was documented on the care plan and if a resident started to display behaviors she created a new

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care plan. She said if a resident was on any psychotropic medications then a care plan was completed. MDS Nurse #2 thought there was a care plan that addressed Resident #131's behaviors and stated, "By now, he should be care planned for behaviors. If they are on psychotropic medications I care plan it and if they have behaviors I care plan it."

An interview was completed with Nurse #1 on 11/15/17 at 3:28 PM. She said she worked the second shift and took care of Resident #131. She reported Resident #131 at times became agitated, threatened and tried to hit staff.

An interview was completed with nurse aide (NA) #1 on 11/16/17 at 11:23 AM. She stated Resident #131 was combative with care at times and had good days and bad days. She reported when Resident #131 had a bad day he would hit at staff with any type of care.

An interview was completed with Resident #131 on 11/16/17 at 11:56 AM. He was confused and his responses to questions were not consistently appropriate to what was being asked.

An interview was completed with the Director of Nursing on 11/16/17 at 1:00 PM. She said she expected that frequent behaviors and psychotropic medications be addressed in the care plan.

2a. Resident #157 was admitted to the facility on 10/4/17 with diagnoses which included: end-stage renal disease and dependence on renal dialysis.

The Admission Minimum Data Set (MDS) dated 10/11/17 indicated Resident #157 was

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moderately, cognitively impaired and received dialysis treatments.

Review of the Care Plan with the onset date of 10/4/17 revealed Resident #157 had the potential for injury, infection and increased feelings of tiredness related to his requiring renal dialysis via the insertion of a permacatheter to his right axilla/chest area. Interventions included: assess permacatheter for patency and for being intact; assess for signs and symptoms of infection at site; vital signs for twenty-four hours post dialysis; and, use aseptic technique for permacatheter dressing change.

The review of the clinical records revealed Resident #157 had a left arm fistulogram procedure at the hospital on 10/27/17.

Review of the Physician's Order dated 10/27/17 instructed nurses to remove the pressure dressing from Resident #157's left arteriovenous fistula (AVF) within four hours of treatment's end time on dialysis days.

Resident #157's Care Plan was not updated to include the care and monitoring of the resident's AVF site.

During an interview on 11/15/17 at 11:14a.m., Staff Nurse #2 (SN#2) stated that Resident #157 received dialysis treatment on Mondays, Wednesdays, and Fridays. SN#2 revealed resident had two dialysis sites; an AVF located in his left upper arm and a permacatheter located in his right upper chest area. SN#2 stated that the resident originally had the permacatheter and the AVF was placed later was the site currently being accessed.

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During an interview with both MDS Nurses on 11/15/17 at 2:35p.m., MDS Nurse #2 stated Care Plans were updated when problems/concerns were reported during the facility's weekly Quality Assurance (QA) meetings. MDS Nurse #1 revealed Resident #157 was admitted to the facility with both the permacatheter and the AVF, but the AVF was not accessible. After reviewing her QA meeting notes, MDS Nurse#1 stated that the resident's new AVF was reported during a QA meeting, but was inadvertently not updated on the Care Plan.

2b. Resident #157 was admitted to the facility on 10/4/17 with diagnoses which included: end-stage renal disease, dependence on renal dialysis and diabetes mellitus.

The Admission Minimum Data Set (MDS) dated 10/11/17 indicated Resident #157 was moderately, cognitively impaired, received a therapeutic diet and received dialysis treatments.

Review of the Care Plan with the onset date of 10/7/17 revealed Resident #157 had the potential for alteration in nutrition related to his therapeutic diet, diagnoses of diabetes mellitus and end-stage renal disease, episodes of frequent nausea and vomiting, and fluid restrictions. Interventions included: diet as ordered, 1500 ml (milliliters) fluid restriction per dialysis, and Glucerna or Ensure (protein supplements) twice each day.

Review of the Progress Note dated 10/23/17, the Registered Dietician recommended liberalizing Resident #157's diet to no concentrated

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sweets/no added salt due to a risk of protein-calorie malnutrition as his calorie and protein needs were increased with hemodialysis.

The review of the Physician's Order dated 11/1/17, the order for Resident #157 to receive Glucerna was discontinued and mighty shake (nutritional supplement) was added twice each day, per the resident's request.

The Care Plan was not updated to include the change in nutritional supplements for Resident #157.

During a meal observation on 11/14/17 at 4:48p.m., Resident #157 received a mighty shake with his dinner meal.

During an interview on 11/15/17 at 11:51a.m., Staff Nurse#2 (SN#2) stated that Resident #157 previously received Glucerna twice each day, but requested and currently received might shakes.

During an interview on 11/15/17 at 12:54p.m., the Dietary Manager (DM) revealed Resident #157 used to receive but refused to drink Ensure (nutritional supplement). The DM stated that the resident currently received and enjoyed magic cups or mighty shakes for additional protein with his lunch and supper.

During an interview on 11/15/17 at 2:46p.m., MDS Nurse#1 revealed the weekly QA Meetings were conducted on Wednesdays. She stated that the Care Plan was not updated because the MDS staff were unaware of the physician's order change of supplement for Resident #157 due to Dietary staff were not in attendance at the meeting on 11/8/17.

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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 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	F 520		12/14/17

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F 520	Continued From page 21 deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews, the facility's Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor interventions that the committee put in to place in following the 9/27/17 complaint investigation survey. This was for one cited deficiency in the area of updating the comprehensive care plan (F280). The facility had a repeat deficiency during the recertification survey conducted on 11/16/17. The continued failure of the facility during two federal surveys shows a pattern of the facility's inability to sustain an effective QAA program. Findings included: This tag is cross referenced to: F280 - Updating the Comprehensive Care Plan - Based on medical record review and staff interviews, the facility failed to revise a pressure ulcer care plan for Resident #3 and Resident #4. This was for 2 of 2 sampled residents reviewed for care plans (Resident #3 and Resident #4). During the recertification survey on 11/16/17, the facility was cited at F280 for failing to update the care plan to reflect documented behaviors and psychotropic medications for one resident and failure to update another resident's care plan to include an arteriovenous fistula (AVF) and a newly ordered supplement. An interview conducted with the Administrator on	F 520	F520 Standard Disclaimer: The plan of correction for this alleged deficient practice is provided as a necessary requirement of continued participation in the Medicare and Medicaid program(s) and does not in any manner constitute an admission to the validity of the alleged deficient practice(s). The Care Plans for Resident #'s 131 and 157 have been updated to reflect those items that were not included in the respective resident's care plan(s). The issue specific to the complaint investigation of 09/27/2017 was specifically related to Infection Control and issues related to the care planning of active infections in wounds, more specifically cultures remarkable for MRSA. The plan correction for the 09/27/2017 complaint investigation was narrowly focused in order to address the singularly identified issue of the facility's failing to revise care plans for residents with wounds which also had active infections. Failing to accurately capture resident behaviors and/or use of psychotropic medications was not an element of the review specific to the 09/17/2017 complaint investigation.	

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F 520	Continued From page 22 11/16/17 at approximately 2:15 PM revealed the facility's QAA program was meeting monthly and working on interventions put into place after the complaint investigation survey in September. She further revealed that the team was mostly focusing on care plans related to infections and wounds and would now pay more attention to care plans in general.	F 520	For those residents having the potential to be affected by the same alleged deficient practice, each member of the Interdisciplinary Care Plan Team has been in-serviced by the Corporate Nurse Consultant specific to the importance of ensuring a resident's care plan is an accurate reflection of the residents' needs. To ensure compliance, the MDS Nurse(s) have completed a 100% audit of all current resident's care plans to ensure the care plans accurately reflect the resident's needs. Such audit(s) have been documented on the Care Plan Audit form which notes 1) the name of the resident reviewed; 2) the date the care plan was reviewed and by whom and 3) what changes/amendments, if any, were made to the resident's care plan. There will be a stand up meeting every morning that the MDS Nurse(s) will attend addressing any changes of condition that would require a change in a residents' care plan. Such audits shall continue monthly for a period of 3 months and shall continue quarterly thereafter or until such time as the Quality Assurance Committee determines there to be no additional need to continue such audits.	