STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345304	A. BUILDING _____ B. WING _____	C 12/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER NURSING CARE/SHAM	2727 SHAMROCK DRIVE CHARLOTTE, NC 28205

(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 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide	F 578		12/31/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/29/2017

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F 578	Continued From page 1 the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to have advanced directives on the medical record for 1 of 3 residents reviewed for advanced directives (Resident #15). The findings included: Resident #15 was admitted to the facility on 04/20/17 with diagnoses of cerebral vascular accident and hemiplegia. Review of the electronic and hard copy medical records for Resident #15 revealed there were no advanced directives for a full code or Do Not Resuscitate directives in the chart. An interview was attempted on 12/08/17 at 12:10 PM with the nurse that readmitted Resident #15 to the facility from the hospital. A voice mail message was left but no return phone call was received from the admitting nurse. An interview, conducted on 12/08/17 at 12:34 PM, with the Director of Nursing revealed Resident #15 was sent out to the hospital last month and the advanced directives must not have been returned from the hospital to the facility. She stated the admitting nurse should have called the hospital and had the advanced directive sent back to the facility. She further stated the advanced directive should have been on Resident #15's chart along with a physician order of preferred code status.	F 578	Brian Center Shamrock acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct in order to maintain compliance with applicable rules and provisions of the CMS Rules of Participation. This plan of correction is submitted as a written allegation of compliance. Preparation and submission of this plan of correction is in response to the CMS 2567 from the survey conducted on December 4-8, 2017. Brian Center Shamrock□s response to this Statement of Deficiencies and Plan of Correction does not denote agreement with the statement nor does it constitute an admission that any deficiency is accurate. Further, Brian Center Shamrock reserves the right to refute any deficiency on this Statement through Informal Dispute Resolution, formal appeal, and/or other administrative or legal procedures. F578 1. The readmitting nurse for Resident #15 failed to ensure a hard copy of advanced directives for Full Code or DNR was placed in the resident□s chart. Resident #15□s advance directives were completed by ADON and a hard copy was placed in the chart. 2. Current residents have the potential to be affected by this finding. Nurse Management audited current residents□	

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F 578	Continued From page 2	F 578	charts to ensure hard copy of advance directives present and physician order for Full Code or DNR entered into electronic record. 3. Area SDC will re-educate Licensed Nurses and Social Service Manager r/t Advance Directives by 12/31/17. The Facility□s process for Advance Directives will be as follow: At the time of Admission/Readmission the nurse will notify the physician of the resident□s or legal representatives wishes, obtains orders as appropriate, and enters the information in the Electronic Health Record. The Social Service Manager will follow up with resident to ensure Advance Directives are completed and hard copy placed in chart. Nurse Management/or designee will randomly audit 5 residents□ chart weekly x 12 weeks to ensure hard copy Advance Directives on chart and code status entered into electronic record. 4. The Director of Nursing/or designee will report findings of the audits to the QAPI committee monthly x 3 to determine the need for additional monitoring and/or education. Date of Compliance: 1/3/18	
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.	F 636		12/31/17

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F 636	Continued From page 3	F 636		

§483.20(b) Comprehensive Assessments
§483.20(b)(1) Resident Assessment Instrument.
A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive

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F 636	Continued From page 4 assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to complete Care Area Assessments that addressed underlying causes and contributing factors for the triggered areas for 4 of 29 sampled residents (Residents #129, #50, #39, and #80). The findings included: 1. Resident #129 was admitted to the facility on 11/17/17. His diagnoses included cellulitis, dysphagia, and Alzheimer's Disease. The admission Minimum Data Set dated 11/24/17 coded him as having severely impaired cognition skills, understanding others and usually being understood. The Care Area Assessment (CAA) dated 12/07/17 for the triggered area of cognition was not completed. There was no analysis of Resident 129's cognition or how his cognition deficit affected his day to day function and ability to make decisions.	F 636	F636 1. The Facility failed to complete Care Area Assessments that addressed underlying causes and contributing factors for the triggered areas for resident #129, #50, #39, and #80. 2. Comprehensive MDS assessments have the potential to be affected by the alleged deficient practice. The RCMD or designee will complete an audit of all current residents receiving a comprehensive assessment during the last 14 days to verify accurate CAA completion per the RAI manual guidelines. Residents with MR numbers 129, 50, 39 and 80 were identified as inaccurate and a correction will be completed by the RCMD or MDS Coordinator with an ARD date of 12/29/17. 3. The District Director of Care Management will re-educate the Resident Care Management Director on accurate CAA completion per the RAI manual guidelines by 12/29/17. The RCMD will	

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F 636	Continued From page 5 Interview with the Social Worker who signed the cognition CAA as completed stated during interview on 12/08/17 at 2:18 PM that she was surprised it was not completed. 2. Resident #50 was admitted to the facility on 01/09/17 with diagnoses including schizophrenia, puerperal psychosis, and major depressive disorder. The admission Minimum Data Set (MDS) dated 01/16/17 coded her as having intact cognition and having received antipsychotic, antidepressant and antianxiety medications 7 out of the previous 7 days. The Care Area Assessment (CAA) dated 01/18/17 for the triggered area of psychotropic drug use stated Resident #50 received psychoactive medication treatments as ordered with a risk for side effects and adverse reactions. She had a history of altered mental status, cerebral vascular accident, psychosis, anxiety, schizophrenia, chronic obstructive pulmonary disease and insomnia. The CAA failed to explain how the medications affected Resident #50's day to day function. Interview with the MDS regional nurse on 12/08/17 at 1:12 PM revealed the psychotropic medication CAA was completed by a former employee. She stated that the CAA would have been on an admission MDS and there would be very little information to use for a CAA analysis. She further stated The MDS nurse who completed the CAA may have had more information she did not put in the CAA.	F 636	re-educate MDS Coordinator and any other IDT members that are completing CAAs on accurate CAA completion per the RAI manual guidelines. The RCMD or designee will randomly audit 5 comprehensive MDS assessments per week for 12 weeks to verify accurate CAA completion per the RAI Manual guidelines. Once completion is achieved, RCMD will audit 1 completed MDS each week for 4 weeks. If no additional issues are identified, the RCMD will then audit 2 completed MDS assessments each month on an ongoing basis. Opportunities will be corrected as identified. 4. The results of these audits will be submitted to the QAPI committee by the RCMD for review by the QAPI committee for 3 months. The QAPI committee will evaluate effectiveness and amend as needed. Date of Compliance: 1/3/18	

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F 636	Continued From page 6	F 636		

3. Resident #39 was admitted to the facility on 03/02/17. Her diagnoses included diabetes, chronic pain, renal disease and schizoaffective disorder.

The admission Minimum Data Set dated 03/09/17 coded her with having intact cognition, having trouble concentrating, having no behaviors, and receiving antipsychotic and antidpressant medications 7 out of the previous 7 days.

The Care Area Assessment (CAA) dated 03/10/17 for the triggered area of psychotropic drug use stated Resident #39 received psychotropic medication treatment with a risk for side effects and adverse reactions. She had a history of chronic obstructive pulmonary disease, diabetes, end stage renal disease, schizoaffective disorder, deep vein thrombosis and amputation. The CAA failed to explain how the medications affected Resident #39's day to day function.

Interview with the MDS regional nurse on 12/08/17 at 1:12 PM revealed the psychotropic medication CAA was completed by a former employee. She stated that the CAA would have been on an admission MDS and there would be very little information to use for a CAA analysis. She further stated the time frame was not long enough to get a clear picture of the resident. The MDS regional nurse then stated the CAA was enough to lead the staff in providing care for her.

4. Resident #80 was admitted to the facility on 07/28/17. His diagnoses included sepsis, respiratory failure, and schizophrenia.

The admission Minimum Data Set (MDS) dated 08/04/17 coded him with moderately impaired

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F 636	Continued From page 7 cognition. The Care Area Assessment (CAA) dated 07/31/17 for the triggered area of cognition only stated that the resident was not able to recall words asked to repeat without a clue. The social worker who completed this assessment was no longer employed by the facility. Interview with the MDS regional nurse, conducted on 12/08/17 at 1:12 PM stated the CAA was based on the Brief Interview for Mental Status (BIMS) and that this was a universal test for determining cognition. She further stated this was enough information as staff relied on facts not on their thoughts of what was the cause and contributing factors of the cognition problem.	F 636		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code behaviors and weight loss for 2 out of 29 sampled residents (Residents#50 and #26). The findings included: 1. Resident #50 was admitted to the facility on 01/09/17 with diagnoses including schizophrenia, psychosis and major depressive disorder.	F 641	F 641 1. The facility failed to accurately code behaviors and weight loss for resident #50 and #26. 2. All residents have the potential to be affected by the alleged deficient practice. The RCMD or designee will complete an audit of all current residents receiving a comprehensive assessment during the last 14 days to verify accurate coding of Section K and E of the MDS per the RAI	12/31/17

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F 641	Continued From page 8 Review of nursing notes revealed a note written on 10/12/17 that stated Resident #50 was verbally aggressive to staff, snatched confidential papers off the nurse cart and threatened to punch the nurse in the face. Resident #50's quarterly Minimum Data Set dated 10/13/17 coded her with intact cognition, having mood indicators including feeling down, trouble sleeping, being tired, feeling bad about herself, and having concentration issues and having no behaviors in the previous 7 days. Interview with the MDS nurse and the MDS regional nurse on 12/08/17 at 1:12 PM revealed there was an error on the MDS for behaviors. 2. Resident #26 was admitted to the facility on 06/06/16 with diagnoses of Alzheimer's disease, cerebral vascular accident and seizure disorder. Review of the annual Minimum Data Set (MDS) dated 11/22/17 revealed Resident #26 was severely cognitively impaired and required extensive assistance with eating. The MDS further revealed Resident #26 was on a physician prescribed weight loss program. Review of the Nutrition Care Area Assessment (CAA) dated 12/01/17 revealed nutritional status triggered for Resident #26 related to mechanically altered diet and significant unplanned weight loss. The CAA stated Resident #26 was at risk for further weight loss related to suboptimal intake at meals to support estimated nutritional needs. Review of the care plan dated 12/01/17 revealed Resident #26 had significant unplanned weight loss with a goal to demonstrate no significant weight loss for 30 days or 90 days. The	F 641	manual guidelines. Residents with MR numbers 26 and 50 will require significant corrections for Quarterly Assessment ARD 10/13/17 (resident #50) and Annual Assessment ARD 11/22/17 (resident #26). The ARD for the Significant Correction for both identified assessments will be 12/29/17. A significant correction will be completed by the RCMD and or MDS designee per the RAI Manual guidelines. 3. The Resident Care Management Director will re-educate the Interdisciplinary Team and MDS Staff on accurate coding related to weight loss and behavior status on 12/29/17. The RCMD will randomly review 5 completed MDSs weekly for 12 weeks to verify accurate coding of Section K and Section E. Opportunities will be corrected as identified as a result of these audits. 4. The results of these audits will be presented by the Resident Care Management Director monthly for 3 months at Facility QAPI meeting. The committee will make changes or recommendations as indicated. Date of Compliance: 1/3/18	

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F 641	Continued From page 9 interventions included a calorie supplement 4 ounces twice a day, monitor weights, labs and intake. An interview conducted on 12/08/17 at 11:59 AM with the Registered Dietician revealed Resident #26 had never been on a physician prescribed weight loss program. An interview conducted on 12/08/17 at 12:30 PM with MDS Nurse #1 revealed physician prescribed weight loss program for Resident #26 was coded wrong on the annual MDS dated 11/22/17. She stated Resident #26 had never been on a physician weight loss program and the MDS should not have been coded as being on a weight loss program.	F 641		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).	F 661		12/31/17

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F 661	Continued From page 10 (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete a recapitulation of stay for 1 of 1 closed records reviewed for a planned discharge (Resident #80). The findings included: Resident #80 was admitted to the facility on 07/28/17 with diagnoses including sepsis, acute ischemic heart disease, respiratory failure, pulmonary edema, schizophrenia and acute kidney failure. Resident #80's admission Minimum Data Set dated 08/04/17 coded him with moderately impaired cognition, receiving occupational and physical therapies, having mood indicators, requiring extensive assistance for most activities of daily living, being nonambulatory, being incontinent, receiving insulin, antipsychotic, anticoagulant and diuretic medications, receiving oxygen and having the expectation to be discharged to the community. Resident #80 was discharged home on 09/08/17. There was an interdisciplinary discharge summary in the medical record which included	F 661	F661 1. The facility failed to complete a recapitulation of stay for Resident#80 who was discharged home on 9/08/17. No residents were affected. 2. Residents that will be discharging after 12/31/17 will have a Discharge Summary completed which includes the recapitulation of stay section. Prior to discharge the Social Service Director will coordinate discharge planning with the assistance of the IDT members. Nursing will be responsible for completing the recapitulation of stay. 3. The Interdisciplinary Team (Nursing, Therapy, Dietary, Activities, MDS, Social Services, and Administrator) were re-educated r/t Discharge Summary by District Director of Clinical Services on 12/27/17. Nurse Management/Medical Records/or designee will audit 3 discharge charts weekly x 12 weeks to ensure Discharge Summary is completed which includes the recapitulation of stay section. 4. The Director of Nursing/or designee will report findings of the audits to the QAPI committee monthly x 3 to determine	

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F 661	Continued From page 11 the reason for admission was intravenous (IV) therapy, medication management and physical, occupational and speech therapies. Treatment provided was IV therapy and physical and occupational therapy. Progress was noted "good-no complications" and reason for discharge was "goals met." The recapitulation of stay failed to include his refusals to wear the bi level positive airway pressure machine at night as ordered, his skin integrity issues requiring interventions, and his refusal for a psychiatric referral due to feeling down. The Director of Nursing stated during interview on 12/08/17 at 11:07 AM that she was unsure of who was responsible for the recapitulation of stay. Interview with the corporate's Staff Development Manager on 12/08/17 at 11:47 AM stated the recapitulation of stay was not complete.	F 661	the need for additional monitoring and/or education. Date of Compliance: 1/3/18	
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to maintain safe hot water temperatures at or below 116 degrees	F 689	F689 1. Based on observation, record review, and staff interviews on 12/4/17, the facility	12/31/17

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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 689	Continued From page 12 Fahrenheit (F), with the maximum noted temperature obtained at 124.5 degrees F, for 17 resident rooms on 3 of 3 hallways (bathrooms for shared rooms 106/108, 113/115, 202/204, 209/211, 210/212, 221/223, 305/307, 313/315 and room 304) and 2 of 2 resident shower rooms (100 and 200 shower rooms). The findings included: Review of the facility's hot water temperature documentation revealed the following: *On 10/04/17 in six rooms across all three resident hallways (100, 200 and 300 halls) temperatures ranged from 118.5 F to 119.1 F. *On 10/11/17 in six rooms across all three resident hallways temperatures ranged from 118.5 F to 119.4 F. *On 10/18/17 in four resident rooms across all three resident hallways, in the beauty shop and in "dietary" temperatures ranged from 119.7 F to 121.2 F. *On 10/26/17 in six resident rooms across all three resident hallways temperatures ranged from 119.2 F to 119.8 F. *On 11/01/17 in six resident rooms across all three resident hallways temperatures ranged from 119.2 F to 119.8 F. *On 11/09/17 in six resident rooms across all three resident hallways temperatures ranged from 118.4 F to 119.5 F. *On 11/16/17 in six resident rooms across all three resident hallways temperatures ranged from 119.8 F to 122.3 F. *On 11/22/17 in six resident rooms across all three resident hallways temperatures ranged from 119.2 F to 120.1 F. *On 11/29/17 in six resident rooms across all three resident hallways temperatures ranged from	F 689	failed to maintain hot water temperatures at or below 116 degrees Fahrenheit, for 17 resident rooms on 3 of 3 hallways and 2 of 2 resident shower rooms. The Maintenance Director immediately corrected the hot water temperatures. No residents were affected. 2. Current residents have the potential to be affected by this finding. "Audit completed by Maintenance Director for residents□ rooms and shower rooms to ensure acceptable temperatures. Maintenance Director/and or designee to document water temperatures each daily, maintenance director/or designee will randomly select the rooms and/or areas where water temperatures are to be read. This will ensure the temperature for the building are at or below 116 degrees Fahrenheit. If the Maintenance Director/and or designee identifies an out of range temperature, an Out of Order sign will be posted outside of the area ensuring residents do not use the water until proper temperatures are maintained. 3. Education provided to Maintenance Director and Administrator by Area Staff Development Coordinator on 12/4/17 r/t Monitoring Water Temperatures. The Maintenance Director/or designee will obtain temperatures for 5 random areas/resident rooms/shower rooms weekly x 12 weeks. The Maintenance Director/or designee will review water temperature log with Administrator weekly x 12 weeks. 4. The Administrator will report findings of the audits to the QAPI committee monthly x 3 to determine the need for	

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F 689	Continued From page 13 118.7 F to 119.6 F. Interview on 12/04/17 at 1:50 PM with the Maintenance Supervisor revealed that the facility hot water supply was on a loop system and that his last check of the hot water temperature at the mixing valve was 120 degrees F. He stated he did random checks in two or three resident rooms once every week and the last check was completed on 11/30/17. He stated he received no resident or staff complaints of excessively hot water. He stated the facility had two hot water tanks that were shared by resident rooms, shower rooms and the kitchen. A tour of facility rooms with hot water supply that residents had access to started on 12/04/17 at 1:52 PM, with hot water temperatures taken with the Maintenance Supervisor's calibrated digital thermometer with the following hot water temperatures observed: *On 12/04/17 at 1:52 PM sink hot water in the 100 hall shower room sink was 124.5 F and shower hot water from the 100 hall shower was 118.1 F. *On 12/04/17 at 1:57 PM sink hot water in the shared bathroom for rooms 106 and 108 was 121.6 F. *On 12/04/17 at 1:59 PM sink hot water in the shared bathroom for rooms 113 and 115 was 122.3 F. *On 12/04/17 at 2:00 PM sink hot water in the 200 hall shower room sink was 120.4 F and shower hot water from the 200 hall shower room was 120.0 F. *On 12/04/17 at 2:05 PM sink hot water in the shared bathroom for rooms 202 and 204 was 119 F. *On 12/04/17 at 2:07 PM sink hot water in the	F 689	additional monitoring and/or education. Date of Compliance: 1/3/18	

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F 689	Continued From page 14 shared bathroom for rooms 209 and 211 was 117 F. *On 12/04/17 at 2:08 PM sink hot water in the shared bathroom for rooms 210 and 212 was 119.8 F. *On 12/04/17 at 2:10 PM sink hot water in the shared bathroom for rooms 221 and 223 was 118.6 F. *On 12/04/17 at 2:12 PM sink hot water in the private bathroom for room 304 was 119.9 F. *On 12/04/17 at 2:15 PM sink hot water in the shared bathroom for rooms 305 and 307 was 116.2 F. *On 12/04/17 at 2:16 PM sink hot water in the shared bathroom for rooms 313 and 315 was 117 F. Observation on 12/04/17 at 2:19 PM revealed the Maintenance Supervisor gaining access to a utility space located just outside of the rear staff entrance of the facility where two large hot water tanks were located. A temperature gauge at the mixing valve was noted to be at 119 F. Interview on 12/04/17 at 2:19 PM with the Maintenance Supervisor checked weekly water temperatures in rooms the goal was to have the hot water temp between 118 and 119 F. Interview on 12/04/17 at 2:25 PM with the Administrator revealed the Administrator expected the facility to maintain water temperatures in a safe and comfortable range. He stated there had not been any resident injuries attributed to hot water and there had been no complaints brought to his attention by staff or residents that water temperatures were too hot.	F 689		
F 692	Nutrition/Hydration Status Maintenance	F 692		12/31/17

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F 692 SS=D	Continued From page 15 CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assess and address weight loss for 1 of 3 residents reviewed for nutritional status (Resident #26). The findings included: Resident #26 was admitted to the facility on 06/06/16 with diagnoses of Alzheimer's disease, cerebral vascular accident and seizure disorder. Review of the physician order's revealed the following: 09/19/16 - Regular diet, puree texture, regular	F 692	F692 1. The facility failed to assess and address weight loss for Resident#26. Resident #26 was assessed by RD #1 on 12/12/17 during which time an increase in PO supplementation was initiated. Since that time weights have stabilized and current nutritional needs are being met without negative outcome. Weekly weights have been implemented and resident is reviewed at the weekly Risk Meetings accordingly with adjustments in interventions made per interdisciplinary team recommendations.	

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F 692	Continued From page 16 consistency. 12/16/16 - House nutritional supplement 2.0 4 ounces twice a day. Review of Resident #26's weights revealed the following: 09/11/17 - 126 pounds 10/16/17 - 116 pounds 10/18/17 - 117 pounds 10/24/17 - 117 pounds 11/05/17 - 113 pounds 11/07/17 - 112 pounds 11/10/17 - 112 pounds 11/13/17 - 112 pounds Review of the annual Minimum Data Set (MDS) dated 11/22/17 revealed Resident #26 was severely cognitively impaired and required extensive assistance with eating. Review of the care plan dated 12/01/17 revealed Resident #26 had significant unplanned weight loss with a goal to demonstrate no significant weight loss for 30 days or 90 days. The interventions included a calorie supplement 4 ounces twice a day, monitor weights, labs and intake. Review of the dietary notes revealed the following: 10/17/17 - 5% change in 30 days, resident is showing a 12 pound weight loss x 30 days. Will re-weigh for accuracy. 11/07/17 - 7.5% change. Resident now showing a loss of 4.6 pounds x 14 days. Resident currently received nutritional supplement 120 milliliters (ml) twice a day. Will refer to the Registered Dietician (RD).	F 692	2. Residents triggering for a significant weight change as evidenced by routine monthly weights will be added to weekly weights in accordance with protocol. Weekly weights will continue on these residents until such time as the Risk Team deems weight is stable, or as situation deems that weekly weights are no longer appropriate. A list of residents falling into this category will be added to the “Weekly Review for Significant Weight Changes” form. The CDM will review weekly weights available on Tuesday of each week which is the scheduled day for the Risk Meeting; note that day of review may be adjusted to accommodate the schedule of the Risk Team in instances where holiday, etc. may necessitate a change. These residents will be discussed accordingly by the team members and the determination will be made whether or not a continuation of weekly weights is appropriate. The CDM will complete the Weekly Review for Significant Weight Changes Form and then will complete a progress note specifying the details of the plan for each resident. The Weekly Review for Significant Weight Changes Form will then be forwarded to the RD for Review and follow-up assessment when indicated. 3. Licensed Nurses and Interdisciplinary Team educated by Area SDC/Nurse Management on Weight/Hydration Management. The RD will complete a full house audit of weights obtained in the facility weekly x 12 weeks. Results of the audit will be logged on the “Significant	

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F 692	Continued From page 17 11/21/17 - Resident was triggering for a 3.4% weight loss x 30 days. Resident has a history of weight loss. Currently received nutritional supplement 120 ml twice a day. Will continue to monitor and refer to RD. 11/28/17 Resident was triggering for a 15.4% weight loss x 90 days. Resident's weight has remained stable for 7 days. Will continue to monitor, RD consulted. 12/05/17 currently triggering for a 12% weight loss x 90 days. Resident's weight has remained stable x 8 days. Will continue to monitor. Review of the facility Nurse Practitioner's progress note dated 11/06/17 revealed Resident #26 was seen at the request of the nurse to follow up on weight loss. Noted with a 4% weight loss over the past month. History of severe dementia. On medication for dementia and depression. Nursing staff reported poor by mouth intake and difficulty taking medications. Impression - weight loss. Plan - continue Remeron, a medication used for depression and appetite stimulant, at 7.5 milligrams every night so it is adequate for appetite stimulation, encourage her to eat, follow weights. Review of RD #1's assessment dated 12/01/17 revealed Resident #26 was at risk for chocking related to dysphagia, swallowing problems. Significant unplanned weight loss identified with risk for further loss related to suboptimal meal intake to support estimated nutritional needs. Continue interventions of 2.0 calorie supplement 4 ounces twice a day, pureed diet as ordered, monitor weights, labs and intake. Request to refer to RD as needed. An interview conducted on 12/08/17 at 11:33 AM	F 692	Weight Change Tracking" form. 4. The Administrator/or designee will report findings of the audits to the QAPI committee monthly x 3 for further review to determine the need for additional monitoring and/or education. Date of Compliance: 1/3/18	

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F 692	Continued From page 18	F 692		

with the Director of Nursing (DON) revealed the facility has 2 RD's for the facility. She stated RD #2 is at the facility every Tuesday to monitor weights and she attended the risk meeting. She stated RD #1 doesn't come as often but she is the one that made new recommendations and interventions for residents with weight loss. The DON stated Resident #26's weight loss from 09/11/17 of 126 pounds to 10/16/17 of 116 was discussed at the risk meeting on 10/17/17 and they decided to reweigh her to see if it was an accurate weight. The DON stated there was no follow up at risk meetings for Resident #26's weight loss after the 10/17/17 risk meeting. She further stated they should have followed up on her weight loss and put interventions in place to prevent further weight loss.

An interview conducted on 12/08/17 at 11:59 AM with the RD #1 revealed she was notified of Resident #26's weight loss until the end of November 2017. She stated she should have been notified of the weight loss after the reweight of 117 pounds on 10/18/17 so she could have assessed the resident and added interventions to prevent further weight loss.

An interview conducted on 12/08/17 1:19 PM with RD #2 revealed she reviews resident weights every Tuesday and attends the risk meetings to discuss weights. She stated the risk committee decided to have Resident #26 reweighed and did not discuss her again at the risk meetings. She stated she should have referred Resident #26 to RD #1 after the reweight showed a true significant weight loss. She stated RD #1 made all recommendations for new interventions and should have been informed.

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F 692	Continued From page 19 An interview conducted on 12/08/17 at 1:31 PM with the facility Nurse Practitioner (NP) revealed she saw Resident #26 on 11/06/17, which was the day the nurse asked her to assess her due to weight loss. She stated no new interventions had been started since the initial weight loss of 10 pounds in October 2017. The NP stated she should have been notified of the initial weight loss so Resident #26 could have been assessed and new interventions added to prevent further weight loss.	F 692		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor the interventions the committee put into place following the recertification/complaint survey of 09/30/16 and complaint survey of 04/12/17. This was for 1 deficiency originally cited in the months of September 2016 and April of 2017 and for 1 deficiency originally cited in the month of September 2016. These 2 tags were subsequently recited on the current recertification and complaint survey of 12/09/17. The 3 federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program.	F 867	F867 1. The Facility Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor the interventions the committee put into place following the recertification/complaint survey of 9/30/16 and complaint survey of 4/12/17 as evidenced by 2 repeat tags F641 Accuracy of Assessments and F689 Free of Accident Supervision. Facility Administrator conducted a Quality Assurance and Improvement Committee meeting on 12/29/2017 to discuss the current survey citations from survey exit on 12/8/17 2. All residents residing in the facility	12/31/17

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F 867	Continued From page 20 The findings included: These tags cross referred to: 1. F641: Accuracy of Assessments: Based on record review and staff interviews, the facility failed to accurately code behaviors and weight loss for 2 out of 29 sampled residents (Residents#50 and #26). During the recertification and complaint survey of 09/30/16, the facility was cited for failure to accurately code Minimum Data Sets for 2 of 28 residents regarding vision and behaviors. During the complaint survey of 04/12/17, the facility was cited for failure to accurately code Minimum Data Sets for 1 of 4 residents regarding skin problems. During an interview on 12/08/17 at 2:35 PM, the Administrator stated the facility failed to maintain compliance with the accuracy of the Minimum Data Sets (MDS) was due to multiple changes in MDS staff and administration resulting in a lack of focus on the problem. He stated that the quality assurance committee should review past deficiencies monthly. 2. F689: Free of Accident Supervision: Based on observation, record review, and staff interviews, the facility failed to maintain safe hot water temperatures at or below 116 degrees Fahrenheit (F), with the maximum noted temperature obtained at 124.5 degrees F, for 17 resident rooms on 3 of 3 hallways (bathrooms for shared rooms 106/108, 113/115, 202/204, 209/211, 210/212, 221/223, 305/307, 313/315 and room 304) and 2 of 2 resident shower rooms (100 and 200 shower rooms).	F 867	have the potential to be affected. 3. The District Director of Clinical Services reeducated the Interdisciplinary team and members of the Quality Assurance and Improvement Committee on 12/27/17 regarding accurately reporting and revising current action plans as well as developing and implementing a new action plans to assure state and federal compliance in the facility. The Quality Improvement Organization has been contacted and will be in facility on 1/3/18 for additional education for facility staff related to the Quality Assurance process. 4. The Interdisciplinary Team including the facility Medical Director will meet at least monthly to conduct the facility□s Quality Assurance and Performance Improvement meeting. Should any interdisciplinary team member find that the facility may need an Adhoc Quality Assurance and Performance Improvement meeting for a facility compliance issue, the Administrator will organize a meeting and notify all team members in order for a revision to any present action plan or for a need for a new action plan in order to maintain compliance in the facility. Quality assurance monitoring will take place at each Quality Assurance and Performance Improvement meeting monthly and any Adhoc meetings held. This monitoring tool will be signed off by each Interdisciplinary team member after each meeting accepting and acknowledging all monitoring and revisions set forth by the Quality Assurance and Performance	

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F 867	Continued From page 21 During the recertification and complaint survey of 09/30/16, the facility was cited for failure to secure siderails to prevent entrapment for 1 of 29 sampled residents. During an interview on 12/08/17 at 2:35 PM, the Administrator stated the facility failed to maintain compliance with maintaining the facility free of accidents due to the past focus and plan of correction was not on water temperatures.	F 867	Improvement committee. The District Director of Operations or designee will review the facility QAPI meeting minutes at least monthly x 3 months. Date of Compliance 1/3/18	