STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345105	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-HIGH POINT	3830 N MAIN STREET HIGH POINT, NC 27265

(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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity 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. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		2/28/18

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

Electronically Signed | 02/26/2018

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F 550	Continued From page 1 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview the facility failed to treat Resident #54 and #69, 2 of 3 residents reviewed for catheter care, with dignity. The facility failed to have Resident #54's and Resident #69's catheter bag covered for privacy and dignity. 1. Review of Resident #54's medical record revealed he was admitted to the facility on 2/9/09 with diagnoses of a neuralgic condition and contractures to his right hip, left hip, and right knee. Review of his Minimum Data Set (MDS) assessment revealed he was cognitively intact and required total assistance with all activities of daily living, such as, turning in bed, transferring, eating, toileting, bathing, and personal hygiene. Resident #54 also required a catheter due to neurogenic bladder. On 1/31/18 at 8:41 am Resident #54 was observed in the common area watching television with five other residents. His catheter bag was hanging from the end of his pants leg with the bag uncovered. The catheter bag was not attached to his chair and hung from his pant leg with no support. There was a privacy bag hanging on the side of his chair unused. On 1/31/18 at 10:23 am Resident #54 was observed again in the common area with the urine catheter bag hanging at the end of his pants leg with the bag uncovered. On 2/1/19 at 8:30 am Resident #54 was observed in bed with the urine catheter bag hanging over	F 550	This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction do not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the state and federal law in order to remove the immediate jeopardy. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents. Process that lead to the deficiency The C.N.A stated she honestly forgot to place the urinary drainage bag into the privacy bag that was available for use. Process for implementing a plan of correction for specific deficiency The facility has implemented the use of the Fig Leaf drainage bag that provides automatic privacy at all times. The Nursing staff will be educated by the Clinical Competency Coordinator by February 24th, 2018 on the use of the Fig Leaf drainage bag. Monitoring to ensure effectiveness of	

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F 550	Continued From page 2 the bedside and was not covered with a privacy bag. Interview with NA #1 on 2/1/18 at 8:54 am revealed Resident #54's urine catheter bag was not covered with a privacy bag. NA #1 stated she would normally place the urine catheter bag in the privacy bag but the privacy bag was attached to Resident #54's wheelchair. Interview with the Director of Nursing on 2/1/18 at 2:51 pm revealed his expectation was urine catheter bags would be covered at all times with a privacy bag to ensure the resident's privacy was protected. 2. Resident #69 was originally admitted to the facility on 3/25/14 and re-admitted on 9/1/17 with diagnoses which included: chronic kidney disease, neuromuscular dysfunction of the bladder, and hemiplegia. Review of the quarterly MDS (Minimum Data Set) dated 1/12/18 indicated Resident #69 was cognitively intact; required extensive assistance of two staff with bed mobility; required total assistance of two staff for transfers; and, had an indwelling catheter. The review of the Care Plan dated 1/23/18 documented Resident #69 as having alteration in urinary processes related to a suprapubic catheter; was at risk for urinary tract infections related to the use of a suprapubic catheter; and	F 550	POC The Director of Nursing and/or Nurse Manager will observe the residents who require catheter□s for the utilization of the Fig Leaf bag daily for 7 days then weekly for 4 weeks then monthly thereafter until 3 consecutive months of sustained compliance is met. The Director of Nursing will report the analysis of the observations to the Quality Assurance and Improvement Committee monthly until 3 months of sustained compliance is met the quarterly. Title of person responsible for implementing the POC The Director of Nursing is responsible for implementing the Plan of Correction Date of Compliance 2/28/18	

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F 550	Continued From page 3	F 550		

had a diagnosis of neurogenic bladder. Approaches included that the catheter's drainage bag be placed in a privacy bag at all times.

During an observation and interview on 1/29/18 at 11:41 a.m., Resident #69 was awake, reclining in a low bed. Hanging from the lower, left side of the resident's bed (in full view from room's doorway) was a catheter drainage bag inside a clear, plastic trashbag. The top end of the trashbag was "wrapped" around the bedrail. The resident revealed he had the catheter for approximately two years, but could not remember why.

During a second observation on 1/31/18 at 8:55 a.m., Resident #69 was sitting up in bed watching television. The uncovered catheter drainage bag containing urine was noted hanging from left side of the bed. An empty, black catheter privacy bag was observed lying flat on the floor next to the bed.

During an observation on 1/31/18 at 9:58 a.m., accompanied by the DON, an empty, black catheter bag was lying on the floor, on the left side of Resident's bed (bed in low position). The uncovered, bottom half of the urine filled, catheter drainage bag was noted touching the floor.

During an interview on 1/31/18 at 10:08 a.m., the DON (Director of Nursing) stated that his expectation was for the catheter bag to be inside the black privacy bag and off the floor. He revealed it was the responsibility of the nurses and the nursing assistants to ensure the catheter bag was off the floor to prevent cross contamination and in a privacy bag to ensure the dignity of the resident. The DON stated that placing a catheter bag in a "personal belongings

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F 550	Continued From page 4 bag" while in use was not acceptable due to the transparency of the bag. The DON revealed the facility was not in short supply of catheter privacy bags and each nursing station maintained a sufficient supply in each medication room as well as in the outside supply room (Central Supply). On 1/31/18 at 11:00 a.m., observation of the medication room at the 200 hall nursing station revealed one box of black catheter privacy bags. During an interview on 2/1/18 at 10:11 a.m., NA#3 (nursing assistant) revealed Resident#69 would often lower his mechanical bed. NA#3 indicated that as a result of the resident lowering his bed, the catheter bag would touch the floor and could become contaminated. NA#3 stated that she would place the resident's catheter bag in the privacy bag in a trash bag and loop the trash bag around the bed rail to keep the catheter bag from touching the floor.	F 550		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(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 (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(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.	F 577		2/28/18

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F 577	Continued From page 5 (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 observations and resident and staff interviews, the facility failed to post their most recent recertification and complaint investigation survey results for three of the four days of the survey. Findings included: 1. On 1/29/18 at 9:30 AM an observation of the survey results box located in the lobby/reception area of the facility revealed no survey results were located inside the box. On 1/30/18 at 9:18 AM an observation of the survey results box located in the lobby/reception area of the facility revealed no survey results were located inside the box. On 1/31/18 at 8:23 AM an observation of the survey results box located in the lobby/reception area of the facility revealed no survey results were located inside the box. On 1/31/18 at 11:43 AM an interview was completed with the Resident Council President (Resident #34). He stated he had no knowledge	F 577	ALLEGED DEFFICIENCIES F577 Survey results not located in the survey results box and residents did not know location of survey book. Process that lead to the deficiency The survey results where located behind the receptionist area which is not accessible to the general public. The Administrator updated the survey book and requested the receptionist replace the book in the survey box. The receptionist placed the book behind the reception area and overlooked placing it back into the survey box. Process for implementing a plan of correction for specific deficiency The survey book was placed into the box after it was noted to be missing. The Administrator will educate the receptionist by 2/24/18 on the regulation regarding the survey book being available for public review at all times.	

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F 577	Continued From page 6 about survey results, nor where they were located in the facility. During the Resident Council meeting on 1/31/18 at 2:30 PM, Resident #10 stated she did not know where the survey results were posted but thought they might be kept at the nurse's station. On 2/1/18 at 8:13 AM an observation of the survey results box located in the lobby/reception area of the facility revealed the survey results notebook was in the box. An interview with the Resident Council President (Resident #34) who was seated in the lobby at the time revealed he asked the Receptionist the previous afternoon about the survey results book and she had the notebook located behind the reception desk. On 2/1/18 at 10:05 AM an interview was completed with the Receptionist. She stated the survey results notebook was behind her desk but she wasn't sure why they were located there and so she placed them back into the survey results box. The Receptionist said residents and families were not permitted to go behind the desk to get the survey results book. On 2/1/18 at 3:00 PM an interview was completed with the Administrator and Director of Nursing (DON). The Administrator stated she wasn't sure why the survey results book was located behind the reception desk but that it was to be kept in the survey results box in the lobby area. She further stated residents and families were unable to access the survey results book if it was behind the desk. The DON said he expected the survey results book to be available to resident and families 24 hours a day.	F 577	The Activity Director will educate the Resident Council regarding survey book location by 2/24/18. The Facility Administration has placed signs at the Nursing Stations and the Activity Room. The Admissions Director and/or Charge Nurse will notify all new admissions of the location of the survey results. Monitoring to ensure effectiveness of POC The Administrator will view the survey box daily to ensure the survey book is available for public review daily for 7 days, weekly for 4 weeks then monthly thereafter. The Administrator will review the analysis of the survey book findings with the Quality Assurance and Performance Improvement Committee monthly until 3 months of sustained compliance is obtained then quarterly. Five Alert and Oriented residents will be randomly asked the location of the Survey Results weekly for 4 weeks them monthly thereafter to ensure the Residents know the location of the survey book. Title of person responsible for implementing the POC The Administrator is responsible for implementation of the Plan of Correction 2/28/18	

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F 658	Continued From page 7	F 658		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and observation the facility failed to follow physician's orders for 2 of 25 residents, Resident #55 and Resident #69. 1. Review of Resident #55's medical record revealed he was admitted to the facility on 10/24/17 with diagnoses of Chronic Kidney Disease, Hypertension and Stroke. Review of the Minimum Data Set (MDS) assessments revealed Resident #55 was severely cognitively impaired. He required extensive assistance with activities of daily living, such as, turning in bed, transferring, eating, toileting, bathing, and personal hygiene. Physician's Order dated 12/29/17 revealed Resident #55's indwelling urinary catheter should be removed on 1/2/17 and if the resident was unable to urinate after 8 hours the physician should be notified. Nurse's Note dated 1/6/18 at 6:00 pm revealed Resident #55's catheter was removed. Nurse's Note dated 1/7/18 at 7:00 pm revealed Resident #55's catheter was reinserted after Resident #55's was unable to urinate. On 2/1/18 at 2:46 pm an interview with the	F 658	Process that lead to the deficiency The Nurse taking the original order did not understand the process when a new order is received at the end of the month to place all new orders on the Medication Administration Record for the following month. Process for implementing a plan of correction for specific deficiency Resident # 69 began a restorative nursing for passive range of motion on 2/2/18. The Clinical Competency Coordinator, Director of Health Services and/or Nurse Mangers began education regarding transcription of orders on 2/20/18 and will be completed by 2/24/18. The Director of Nursing has implemented a 24 hour chart check that encompasses physician orders written within the last 24 hours. The Charge Nurse will review each chart and identify on the form all new orders received and document follow up to the orders. The Form will then be given to the Director of Health Services to validate completion of all orders.	2/28/18

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F 658	Continued From page 8 Director of Nursing revealed his expectation would be that all physician's orders would be followed as ordered. 2. Resident #69 was originally admitted to the facility on 3/25/14 and re-admitted on 9/1/17 with diagnoses which included: cerebrovascular accident (CVA) and hemiplegia. Review of the quarterly MDS (Minimum Data Set) dated 1/12/18 indicated Resident #69 was cognitively intact; required extensive assistance of two staff with bed mobility; required total assistance of two staff for transfers; and, limited range of motion on both sides of the upper and lower extremities. Review of the Physician's Order dated 1/19/18 revealed Resident #69 was to discontinue OT (Occupational Therapy) and start Restorative Services. The Care Plan dated 1/23/18 documented Resident #69 required total assistance with all of his activities of daily living related to impaired mobility secondary to a history of CVA with resulting hemiplegia. Approaches included: passive range of motion during daily care; turn and reposition frequently; and use of the mechanical lift for transfers. During an interview on 2/1/18 at 10:11 a.m., NA#3 (nursing assistant) stated that Resident #69 was paralyzed on his left side and she always turned and repositioned the resident three times during	F 658	Monitoring to ensure effectiveness of POC The Director of Health Services and/or Nurse Managers will validate the 24 hour chart check given to them by the Charge Nurses Daily for 7 days them weekly thereafter for 4 weeks then monthly until 6 months of sustained compliance is obtained. The Director of Nursing will present the analysis of the review to the Quality Assurance and Performance Committee monthly until 3 months of sustained compliance is maintained then quarterly. Title of person responsible for implementing the POC The Director of Health Services is responsible for implementation of the plan of correction 2/24/18	

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F 658	Continued From page 9 first shift. NA#3 also revealed the resident was transferred to his high-back wheelchair using a mechanical lift and two staff. During an interview on 2/1/18 at 11:09 a.m., the PTA (physical therapy assistant) revealed Resident #69 received OT (occupational therapy) for positioning support for his left arm while in bed and chair and the goal was met. The resident received PT (physical therapy) for ROM (range of motion) of his lower left extremity due to edema. She stated that the resident's ROM was increased and his edema was reduced. As a result, PT and OT were discontinued for the resident on 1/19/18. The PTA indicated the resident was not referred to nursing for Restorative Service; family and caregiver education was provided for ROM. During an interview on 2/1/18 at 11:25 a.m., the Restorative Nurse revealed Resident #69 was not receiving Restorative Services and was not on the Restorative Service's schedule. She indicated she had not received a referral for the resident to receive Restorative Services and was not informed of the Physician's Order for the resident to receive Restorative Services.	F 658		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690		2/28/18

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F 690	Continued From page 10 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview the facility failed to provide a functional urine catheter bag for Resident #54, 1 of 3 residents observed with urine catheters. Resident #54 was observed to have a broken attachment hook on his catheter bag and staff allowed the catheter bag to hang freely putting the resident in risk of trauma. Review of Resident #54's medical record revealed he was admitted to the facility on 2/9/09	F 690	Process that lead to the deficiency The C.N.A stated she honestly forgot to place the urinary drainage bag into the privacy bag that was available for use. Process for implementing a plan of correction for specific deficiency The facility has implemented the use of the Fig Leaf drainage bag that provides	

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F 690	Continued From page 11 with diagnoses of a neurological condition and contractures to his right hip, left hip, and right knee. Resident #54 also had a history of Septic Shock from a Urinary Infection. Review of his Minimum Data Set (MDS) assessment revealed he was cognitively intact and required total assistance with all activities of daily living, such as, turning in bed, transferring, eating, toileting, bathing, and personal hygiene. Resident #54 also required a catheter for urination due to neurogenic bladder. On 1/31/18 at 8:41 am Resident #54 was observed in the common area watching television with five other residents. His urine catheter bag was hanging from the end of his pants leg with the bag uncovered. The urine catheter bag was not attached and was hanging freely. On 1/31/18 at 10:23 am Resident #54 was observed again in the common area with the urine catheter bag hanging at the end of his pants leg. On 2/1/19 at 8:30 am Resident #54 was observed in bed with the urine catheter bag hanging over the bedside. The bag was not attached to the bed and was hanging freely. Interview with NA #1 on 2/1/18 at 8:54 am revealed Resident #54's urine catheter bag was hanging freely because the attachment hook was broken. NA #1 stated she would normally place the urine catheter bag in the privacy bag but it was attached to Resident #54's wheelchair. Interview with the Director of Nursing on 2/1/18 at 2:51 pm revealed his expectation was urine catheter bags would be secured and the bag	F 690	automatic privacy at all times. The Nursing staff will be educated by the Clinical Competency Coordinator by February 24th, 2018 on the use of the Fig Leaf drainage bag. Monitoring to ensure effectiveness of POC The Director of Nursing and/or Nurse Manager will observe the residents who require catheter□s for the utilization of the Fig Leaf bag daily for 7 days then weekly for 4 weeks then monthly thereafter until 3 consecutive months of sustained compliance is met. The Director of Nursing will report the analysis of the observations to the Quality Assurance and Improvement Committee monthly until 3 months of sustained compliance is met. Title of person responsible for implementing the POC The Director of Nursing is responsible for implementing the Plan of Correction Date of Compliance 2/28/18	

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F 690	Continued From page 12 would be changed if there were any broken parts to the catheter or the urine bag.	F 690		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(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. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to dispose of expired tube feeding and intravenous tubing and failed to ensure labeling of intravenous antibiotic vials in 2 of 3 medication storage rooms.	F 761	Process that lead to the deficiency Expired items and/or unlabeled items in the medication rooms where not discarded when they expired. The nurses were unaware that they	2/28/18

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F 761	Continued From page 13 Findings included: A. On 2/1/18 at 1:45 PM, an observation of the medication storage room on the 200-hall revealed 4 bottles of Jevity 1.2 calorie tube feeding with expiration dates of 10/1/17. The assigned nurse for the 200 hall was unavailable for interview at that time because a new admission had just arrived to the facility. B. On 2/1/18 at 2:12 PM, an observation of the medication storage room on the 100-hall revealed 2 bags of intravenous drip tubing with expiration dates of 10/22/17 and 6 vials of unlabeled cefazolin in an unlabeled zip lock bag in a cardboard box. An interview with Nurse #1 on 2/1/18 at 2:15 PM revealed she did not know how the unlabeled vials of the medication got there and she was unaware of the expired intravenous tubing. Nurse #1 further revealed that she is the one that typically cleans the medication room on her shift, but hadn't done it that day and was not aware of any process in place to address it. On 2/1/18 at 2:30 PM, an interview conducted with the Director of Health Services revealed that he was unaware of the expired and unlabeled items in the medication rooms and that it was unacceptable. He revealed the expectation was that expired tube feeding should be discarded, medications should be labeled properly and expired supplies should be removed. On 2/1/18 at 4:32 PM, an interview with the Administrator revealed that the DNS goes through the medication carts and medication rooms monthly, but could not produce any documentation of a system or process in place as to who is responsible.	F 761	should complete a weekly medication room review to remove all expired medication. This is related to a break down in education related to label/Store Drugs and Biologics. Process for implementing a plan of correction for specific deficiency The Clinical Competency Coordinator, Director of Health Services and/or Nurse Managers are educating the Licensed Nurses on Labels/Storage of Drugs and Biologicals. All scheduled Licensed Nurses will be educated by 2/24/18. The Licensed Nurses will review their assigned Medication Rooms and Medication Carts for unlabeled Medications and Biologics as well as expired Medications and Biologics daily for 7 days then weekly thereafter. The Licensed Nurse review will be given to the Director of Health Services to validate the removal of all expired and/or unlabeled medications and biologics. Monitoring to ensure effectiveness of POC The Director of Nursing and/or Nurse Mangers will validate the License Nurse review of the Medication rooms and medication carts daily for 7 days then weekly thereafter for 4 weeks then monthly thereafter. The Director of Health Services will present an analysis of their review to the Quality Assurance/ Performance Improvement committee monthly until 3 consecutive months of	

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F 761	Continued From page 14	F 761	compliance is sustained then quarterly. Title of person responsible for implementing the POC The Director of Nursing is responsible to implement the plan of correction. 2/28/18	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain sanitary conditions in the kitchen by not ensuring by not ensuring dishware were sanitized in the low temperature dishwashing machine; by not ensuring opened food items were resealed, dated and labeled; by	F 812	Process that lead to the deficiency Certified Dietary Manager and Cooks did not complete their daily sanitation rounds daily.	2/28/18

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F 812	Continued From page 15 not ensuring muffin tins, cooking and serving utensils were stacked and stored clean and free from debris; and, by not maintaining sanitary conditions in the nourishment room. Findings included: 1. During the initial tour of the kitchen on 1/29/18 at 9:34 a.m., two wash and sanitizing cycles of dishes in the low-temperature dishwashing machine (verified by the Dietary Manager) were observed. The first cycle yielded the wash temperature of 80 degrees Fahrenheit (less than the required minimum of 120 degrees Fahrenheit) and sanitizer reading of 75 ppm (parts per million) chlorine. The second cycle yielded the wash temperature of 96 degrees Fahrenheit (less than the required minimum of 120 degrees Fahrenheit) and sanitizer reading of 100ppm chlorine (greater than the required 50ppm chlorine). During an interview on 1/29/18 at 9:43 a.m., Dietary Staff #1 stated that when washing dishware, the temperature of the water in the dishwashing machine should be between 115 degrees Fahrenheit and 120 degrees Fahrenheit and the sanitizer reading should be between 100-200 ppm chlorine. She revealed that if the water temperature dropped below 115 degrees Fahrenheit, she would inform the Dietary Manager, as soon as possible and the dishware would have to be rewashed. 2. During the initial tour of the kitchen on 1/29/18 at 9:56 a.m., observation of the reach-in freezer #1 revealed: 1-resealed but not dated bag of chicken tenderloins; 1-open and not dated bag of	F 812	Process for implementing a plan of correction for specific deficiency The Food and Nutrition staff began education on 2/2/18 related to sanitary conditions in the kitchen including: correct temperatures for the low temperature dish-machine, resealing, dating and labeling opened food items, storage of cooking utensils and serving utensils being stacked and stored free of debris. The food and nutrition staff and the nursing staff began education on 2/2/18 on maintaining sanitary conditions in the nourishment rooms. The Certified Dietary Manager/Cook will complete the Compliance Rounds Dining Service review daily. This review includes: correct temperatures for the low temperature dish-machine, resealing, dating and labeling opened food items, storage of cooking utensils and serving utensils being stacked and stored free of debris, and that no personal items are located in the nourishment rooms. Monitoring to ensure effectiveness of POC The Certified Dietary Manager and/or Cook will correlate the analyze the information from the Compliance Rounds Dining Services daily and report the findings to the Quality Assurance and Performance Improvement Committee for review and recommendations monthly until 3 consecutive months of compliance is sustained, then quarterly thereafter.	

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F 812	Continued From page 16 potato puffs; 1-resealed, plastic wrapped potato puffs; and 1-sleeve of turkey meat in a bin containing resealed and dated bags of frozen vegetables. The reach-in refrigerator #1 contained a tray of four ounce soufflé cups of pudding that were not dated. The DM (Dietary Manager) revealed the cups of pudding were for use the night of 1/28/18 by the nurses during the administration of medications. The refrigerator also consisted of 1-large container of dark colored liquid that was not dated or labeled. The DM revealed the liquid was grape drink and should have been labeled. There were 3-large bins (containing flour, sugar, and cornmeal) in the dry storage room that were not labeled. On one of the storage racks in the dry storage room, there was a large gray bin containing a white substance (which the DM identified as thickener) and a medium sized bin containing rice that were not dated or labeled. During an observation of the kitchen on 2/1/18 at 1:15 p.m., the dry storage room consisted of: 1-resealed bag of gravy mix dated 10/18/16; 1-resealed but not dated bag of coconut flakes; 2-resealed but not dated bags of dry cereal; 1-resealed bag of potato chips; and 2-resealed but not dated bags of pasta. There was 1-opened (not covered) container of thickener on a preparation table in the kitchen preparation area. 3. During a kitchen observation on 1/29/18 at 10:29 a.m., on the dry storage rack with cleaned utensils, pots and pans were; 1-small greasy container with white residue; and, 1-plastic scoop covered with a white powdery substance. On an open-sided delivery cart containing clean stainless steel sheet trays were 4-stacked, large	F 812	Title of person responsible for implementing the POC The Certified Dietary Manager is responsible for implementing the plan of correction. 2/28/18	

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F 812	Continued From page 17	F 812		

greasy and stained muffin tins; 1-greasy and stained griddle; and 1-four quart greasy pot.

On 2/1/18 at 12:46 p.m., during a kitchen observation, an employee's purse was noted on a storage rack, next to a case of bananas, in the kitchen. The DM revealed the purse belonged to a new employee but there was no excuse for the employee to store her belongings in the kitchen.

4. During a tour of the 300 hall nourishment room on 2/1/18 at 1:30 p.m., revealed the freezer section of the compact refrigerator was covered with thick condensation. The refrigerator contained a pitcher of dark colored liquid and a resealed bottle of salad dressing that were not dated or labeled. The toaster/cookie over on the countertop was dirt with crumbs on the inside. There was a plastic bag on the countertop containing a hinged tray of partially consumed breakfast food with "Pattie" written on it. There were two used cups noted on the countertop. There were resealed but not dated bags of vanilla wafers stored in the cabinets.

During an interview on 2/1/18 at 1:51 p.m., Housekeeping Staff stated that dietary staff were responsible for cleaning the nourishment/pantry refrigerator but she would sometimes help out.

During an interview on 2/1/18 at 1:54 p.m., the DON revealed Dietary was responsible for maintain the refrigerator/freezer in the pantry/nourishment room. Housekeeping was responsible for cleaning the counter-space, floor and sink. He indicated dietary and nursing were to keep the cabinets clean. The DON stated that facility employees were not to store any of their

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F 812	Continued From page 18 personal items in the pantry/nourishment room; the facility had an employee lounge with a refrigerator.	F 812		
F 867 SS=F	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 review and staff interviews, the facilities Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor their interventions that the committee put into place following the recertification survey conducted on 1/11/17. This was for two cited deficiencies in the areas of Medication Storage and (F431) and Services Meet Professional Standards (F281). The facility had two repeat deficiencies during the recertification survey conducted on 2/1/18. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referenced to: 1. F761 - Drug Labeling and Storage- Based on observations and staff interviews, the facility failed to discard expired tube feeding and intravenous tubing and failed to label vials of	F 867	Process that lead to the deficiency The Quality Assurance Committee did not maintain implemented procedures and monitor their interventions after 3 consecutive months of compliance. Process for implementing a plan of correction for specific deficiency The Quality Assurance and Performance Improvement Committee will continually monitor implemented procedures and monitor the interventions put into place monthly until 3 consecutive months of compliance is maintained then quarterly thereafter. The QAPI team will be re-educated via watching QAPI Root Cause Analysis & PIP Development for SNF via Relias. Quality Assurance and Performance Improvement Committee meets monthly to review the tracking and trending	2/28/18

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F 867	Continued From page 19 antibiotics. secure one of four medication carts located on the 100/200 hall During the recertification survey of 1/11/17, the facility was cited at F431 for failing to secure one of four medication carts located on the 100/200 hall. 2. F658 - Based on observations, record review and staff interviews, the facility failed to follow physician's orders for Resident # 69 and Resident #5 on 1 of 5 residents reviewed for unnecessary medications. (Resident #75) During the recertification survey of 1/11/17, the facility was cited at F281 for failing to follow physician orders for 1 of 5 residents (Resident #75) reviewed for unnecessary medications. An interview conducted with the Administrator on 2/1/18 at 4:32 PM revealed the facility did have an active Quality Assessment and Assurance Committee and they met monthly usually on the third Thursday. The committee did not meet as scheduled last week due to inclement weather. The committee is comprised of all department heads and the Medical Director. The administrator revealed the committee is currently working on mock evacuations and emergency preparedness. She revealed they are also working on the restorative program and updating care plans in the morning meetings. She further revealed the Director of Nursing Services goes through the medication carts and medication storage rooms monthly, the nurses go through their carts to check for narcotics that aren't being used and the pharmacy goes through medication carts during their monthly reviews, and they would have to put more focus on it.	F 867	analysis of each department□s performance improvement plan. The agenda will include the developing of a retrospective effort to examine certain facility standards and determine the reasons for failure to meet any standards. The Quality Assurance and Performance Improvement Committee will develop systemic procedures and new approaches to repair causes of failed procedures. Monitoring to ensure effectiveness of POC The Regional Team (Area Vice President and/or Senior Nurse Consultant) will attend and review the Quality Assurance and Performance Improvement Committee progress with continued implementation of procedures and monitor the interventions put into place. The Regional Team will make changes to the committee□s approach as deemed necessary. Title of person responsible for implementing the POC The Administrator is responsible for implementation of the plan of correction with oversight by the Regional Team. 2/28/18	

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F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		2/28/18

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F 880	Continued From page 21 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview the facility failed follow ordered infection control precautions for 1 of 8 residents, Resident #49, placed on droplet precautions. Resident #49 was placed on droplet precautions for a positive influenza swab test. A medical record review revealed Resident #49 had a diagnoses of Dementia, Depression, Anxiety, and Schizophrenia. A review of the Minimum Data Set (MDS) assessments showed	F 880	Process that lead to the deficiency The Employee stated she forgot to put a mask on the resident and utilize a gown, gloves and mask herself during transport to the shower room. Process for implementing a plan of correction for specific deficiency The Clinical Competency Coordinator	

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F 880	Continued From page 22 Resident #49 required extensive assistance with activities of daily living, such as, turning in bed, transferring to a wheelchair, bathing, dressing, toileting and eating. It also revealed she was severely cognitively impaired. Physician's order written 1/22/18 revealed Resident #49 had a positive nasal swab for influenza, and was placed precautions. There was a droplet precautions sign posted at the doorway of Resident #49's room and a rolling cabinet with gowns, masks and gloves. Observation on 1/30/18 at 2:37 pm revealed Resident #49 was brought from the shower room back to hallway outside her doorway and left in her wheelchair with no mask on. NA #2 was not wearing any personal protective equipment, such as, a gown, gloves or mask. NA #2 entered Resident #49's room and changed the linen on Resident #2's bed, leaving Resident #49 in her wheelchair in the hallway. During an interview on 1/30/18 at 2:57 pm NA #2 stated she knew she forgot to put a mask on Resident #49 before she took her to the shower and she did not wear a gown, mask, and gloves herself. Interview with Nurse #1 on 1/30/18 at 3:08 pm revealed NA #2 should have worn a gown, mask and gloves before going into Resident #49's room and placed a mask on Resident #49 before taking her from her room to the shower. Nurse #1 stated Resident #49 should have been placed back in her room and not in the hallway. Interview with the Director of Nursing on 2/1/18 at 2:57 pm revealed his expectation was staff would	F 880	and/or Nurse Managers began educating all staff regarding the use of personal protective equipment related to infections on 2/15/18 and is ongoing. The Licensed Nurses, Nurse Mangers and/or Department Managers are observing staff going into resident□s rooms on droplet and/or contact precautions and observing employees transport resident with droplet and/or contact precautions to review that appropriate protective equipment is worn by the employee as well as resident daily. The observations are given to the Director of Nursing and/or Clinical Competency Coordinator for analysis and trending. Monitoring to ensure effectiveness of POC The Director of Health Services and/or Clinical Competency Coordinator will correlate the data from the Licensed Nurse / Department Manager review weekly and present the analysis to the Quality Assurance / Performance Improvement Committee monthly until 3 months of sustained compliance is observed then quarterly thereafter. Title of person responsible for implementing the POC The Administrator is responsible for the implementation of the plan of correction. 2/28/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345105	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 23 follow precautions and policies to protect themselves and the other residents.	F 880		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations and resident and staff interviews, the facility failed to maintain the pull cord of a bathroom call light for 1 of 5 bathrooms inspected (shared bathroom for rooms 218 and 219). Findings included: 1. On 1/31/18 at 8:30 AM an observation was completed of the shared bathroom for rooms 218 and 219. The call light button was located next to the commode and had an approximately three inch long plastic cord with no extension cord or string attached to it. On 1/31/18 at 3:00 PM an interview and tour was completed with the Maintenance Director. The Maintenance Director stated he was unaware there was no extension cord attached to the bathroom call light for rooms 218 and 219. He further stated he was in that particular bathroom on 1/30/18 and repaired a clogged sink. He performed a visual check of the bathroom at that	F 919	Process that lead to the deficiency The Maintenance Director did not have a process in place to identify call bells that had shortened cords. Process for implementing a plan of correction for specific deficiency The Maintenance Director was educated by the Administrator regarding preventative maintenance related to call bell extension being available on all call cords as needed. The Maintenance Director \Housekeeping Director will conduct daily preventative rounds on call cords to validate that each cord has the appropriate extension available. Call Cords without extensions will be replaced immediately. All staff was educated by the Maintenance Director, Clinical Competency Coordinator and/or Department managers regarding	2/28/18

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 919	Continued From page 24	F 919		

time but said he missed the pull cord on the call light. The Maintenance Director said he tried to check each resident's room and bathroom at least monthly for needed repairs but did not keep a recorded log or schedule of rooms that he had checked. He stated if he found items that needed to be addressed or repaired he wrote it down in his planner but if there were no issues identified it wasn't documented.

On 1/31/18 at 4:32 PM an interview was completed with the resident in Room 219B (Resident #63). The resident stated he used the commode and took himself to the bathroom without staff assistance.

On 2/1/18 at 10:37 AM an observation of the bathroom between rooms 218 and 219 revealed no cord extension had been attached to the call light.

On 2/1/18 at 10:40 AM an interview was completed with Nurse Aide (NA) #3. She stated the resident in Room 218A (Resident #23) used the commode and took himself to the bathroom without staff assistance.

On 2/1/18 at 2:55 PM an observation of the bathroom between rooms 218 and 219 revealed no cord extension had been attached to the call light.

On 2/1/18 at 3:00 PM an interview was completed with the Administrator and Director of Nursing (DON). The DON stated that for residents' safety, he expected extension cords be attached to call lights in the bathrooms.

observing that call bell extensions are available and if they are not present to notify the Maintenance Director for replacement.

Monitoring to ensure effectiveness of POC

The Maintenance Director will trend and analyze the data compiled from the Call Bell preventative Rounds and present findings to the Quality Assurance and Performance Improvement Committee monthly until three months of substantial compliance ins maintained them they will present findings quarterly.

Title of person responsible for implementing the POC

The Maintenance Director is responsible for implementation of the plan of correction. 2/28/18