STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345223	A. BUILDING _____ B. WING _____	C 02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE HEALTH AND REHABILITATION CENTER	1510 HEBRON STREET HENDERSONVILLE, NC 28739

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F 000	INITIAL COMMENTS A recertification and complaint survey was conducted from 02/12/18 through 02/16/18. Past-noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity of G.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.	F 561		3/19/18

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

Electronically Signed | 03/12/2018

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F 561	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to provide a resident with their preferred number of showers a week for 1 of 1 resident reviewed for choices (Resident #39). Findings included: Resident #39 was admitted to the facility on 05/27/16 with diagnoses that included chronic kidney disease, muscle weakness, lack of coordination, difficulty walking, and anxiety disorder. The quarterly Minimum Data Set (MDS) dated 01/06/18 indicated Resident #39 was cognitively intact and displayed no rejection of care. Further review of the MDS revealed Resident #39 required the physical assistance of 1 staff member for dressing, personal hygiene and bathing. Review of Resident #39's Activities of Daily Living (ADL) care plan, with a review date of 01/16/18, addressed her need for staff assistance due to an ADL self-care performance deficit. Interventions included resident requires supervision to total staff assistance with ADL care depending upon medical status and function. Review of the Nurse Aide (NA) care guide (summarized individual care needs of residents) updated on 02/12/18 indicated Resident #39's scheduled shower days were Wednesday and Sunday during the hours of 7:00 AM to 3:00 PM. Further review revealed she was a falls risk.	F 561	F561 This alleged deficiency was caused by Resident Care Specialist's (CNA) failure to follow established shower schedules. How will corrective action be accomplished for those residents found to have been affected by the deficient practice: Resident #39 was provided a shower on 2/14/18 by a Resident Care Specialist (CNA). Resident Care Specialists and Unit Coordinators will be provided in-service education by the Director of Nursing on following established shower schedules on or before 3/19/18. How will corrective action be accomplished for those residents having the potential to be affected by the same deficient practice: An audit of resident shower schedules for each nursing unit will be completed by the Director of Nursing, Unit Coordinator(s) and Staff Scheduler on or before 3/19/18 to ensure showers, tub baths, and/or shampoos are scheduled at least twice weekly and more often as needed or requested. Any identified issues will be corrected immediately by the Unit Coordinators and/or Director of Nursing. What measures will be put into place or systematic changes made to ensure the deficient practice does not recur:	

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F 561	Continued From page 2 During an interview on 02/14/18 at 1:20 PM Resident #39 stated she was supposed to receive showers twice a week on Sundays and Wednesday but was only getting one. Resident #39 added she did not receive her scheduled shower on 02/11/18 because staff stated they were too busy. During a follow-up interview on 02/16/18 at 10:20 AM Resident #39 stated she would "clean up a little every day" and added she enjoyed receiving a shower. Resident #39 explained during a shower she tried to do as much of the bathing activity as possible but relied on staff to assist her with cleaning areas she was unable to reach. Review of the electronic medical record for Resident #39 revealed NA documentation which indicated ADL bathing activity occurred on 02/11/18. Further review revealed ADL bathing activity did not occur on 12/31/17, 01/03/18, 01/10/18, 01/21/18, 01/31/18 or 02/04/18. There was no documentation she had refused bathing assistance when offered by staff. A telephone attempt made on 02/16/18 at 11:01 AM to interview NA #3, who worked on 02/11/18, was unsuccessful. During interviews on 02/16/18 at 5:05 PM and 6:20 PM the Director of Nursing (DON) stated she reviewed Resident #39's electronic ADL documentation and staff verified Resident #39 received a "bed bath" on 02/11/18. She confirmed there was no documentation to support bathing assistance was provided to Resident #39 on 12/31/17, 01/03/18, 01/10/18, 01/21/18, 01/31/18, and 02/04/18. The DON stated it was her expectation residents would receive bathing	F 561	Current Licensed Nurses and Resident Care Specialists will be educated by the Director of Nursing, Staff Development Coordinator, RN Supervisor and/or Unit Coordinators on or before 3/19/18 regarding the requirements for compliance with F561-Self Determination. The resident has the right to, and the facility must promote and facilitate resident self-determination through support of resident choice. How the corrective actions will be monitored toEnsure the practice will not recur, i.e. what Quality assurance program will be put into place: To ensure ongoing compliance, Licensed Nurses and/or Unit Coordinators will verify that showers scheduled for the previous day are completed according to the shower schedule and resident choice using an audit tool daily for four (4) weeks, then three (3) times a week for four (4) weeks and then monthly for one (1) month or until compliance has been determined. Any identified discrepancies will be corrected immediately with re-education provided as necessary. The results of these audits will be reported at the monthly QAPI meeting until such time substantial compliance has been achieved and the committee recommends quarterly oversight by the Director of Clinical Services or designee to maintain compliance when completing	

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F 561	Continued From page 3 assistance as scheduled. During a follow-up interview on 02/16/18 at 6:58 PM Resident #39 confirmed she did not receive a bed bath or shower on 02/11/18 and stated, "if you want to consider me washing up in the sink a bed bath then I guess so." During a telephone interview on 02/16/18 at 7:04 PM Nurse #2 recalled she worked as a NA during first shift on 02/11/18 and noticed Resident #39 washing herself off at the sink when she went to pick up her breakfast tray. Nurse #2 stated Resident #39 indicated she wanted to go to church and couldn't wait any longer for staff to give her a shower. Nurse #2 stated she had documented the activity as a "partial bath." Nurse #2 confirmed Resident #39 was not offered or provided a shower during the remainder of the shift.	F 561	Clinical Systems Review. The Director of Nursing is responsible for implementing the acceptable plan of correction.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.	F 584		3/19/18

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F 584	Continued From page 4 (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to secure loose heating/air conditioning covers and failed to repair a vented light cover that had come loose from the wall in 4 of 13 resident rooms (Rooms #12, #13, #19 and #22). The facility also failed to replace a toilet tank lid that was unsecured and too long to fit the tank and failed to repair baseboard that had peeled back from the wall in 2 of 7 resident bathrooms (Rooms #20 and #21). In addition, the facility failed to maintain clean and sanitary linen closets on 1 of 2 resident hallways (East hall).	F 584	F584 This alleged deficiency was caused by staff members failure to follow established policies and procedures related to maintaining clean linen rooms and routinely inspecting resident rooms and reporting necessary maintenance issues. How will corrective action be accomplished for those residents found to have been affected by the deficient practice:	

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F 584	Continued From page 5 Findings included: 1. a. Observations of resident room #12 on 02/12/18 at 11:46 AM revealed the heating/air conditioning unit cover was loose and exposed an inch gap between the unit and wall. Additional observations on 02/13/18 at 5:11 PM and on 02/14/18 at 2:51 PM revealed the conditions remained unchanged. b. Observations of resident room #13 on 02/12/18 at 11:47 AM revealed a vented light cover on the lower part of the wall was loose and sticking out from the wall. Additional observations on 02/13/18 at 5:13 PM and 02/14/18 at 2:52 PM revealed the conditions remained unchanged. c. Observations of resident room #19 on 02/12/18 at 11:50 AM revealed the heating/air conditioning unit cover was loose and exposed an inch gap between the unit and wall. Additional observations on 02/13/18 at 5:15 PM and on 02/14/18 at 2:54 PM revealed the conditions remained unchanged. d. Observations of resident room #22 on 02/12/18 at 11:57 AM revealed the heating/air conditioning unit cover was loose and exposed an inch gap between the unit and wall. Additional observations on 02/13/18 at 5:19 PM and on 02/14/18 at 2:57 PM revealed the conditions remained unchanged. During an interview and environmental tour on 02/15/18 at 2:00 PM the Maintenance Director (MD) revealed staff were expected to use the facility work order system to report repairs needed but would often inform him verbally. The	F 584	The heating/ air conditioning (PTAC) unit covers in rooms 12, 19 and 22 were adjusted and secured to the units by the Maintenance Director on 2/15/18. The loose vented light cover in room 13 was repaired and secured to the wall by the Maintenance Director on 2/15/18. The toilet tank cover in room 20 was replaced by the Maintenance Director on 2/15/18. The loose cove base in the bathroom of room 21 was repaired by the Maintenance Director on 2/15/18. The East Wing linen closet was cleaned and organized on 2/12/18 by housekeeping and the disposable diaper, disposable gloves, open boxes of gloves, toilet paper, and comb on the floor were all discarded. The blankets, cloth incontinence pads, mechanical lift pad, and pillow were all sent to laundry and were cleaned. How will corrective action be accomplished for those residents having the potential to be affected by the same deficient practice: An inspection of other resident rooms and clean linen closets was completed by the Administrator, Maintenance Director, and Housekeeping Supervisor on 3/6/18 to determine if there were other loose PTAC unit covers, non- fitting toilet tank covers, loose vented light covers, and missing or loose cove base. Those identified will be repaired or replaced as necessary by the Maintenance Director, or other contractor	

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F 584	Continued From page 6 MD explained he was the only employee in the maintenance department and would make repairs as they were noticed or reported. The MD confirmed he was not aware of the repairs needed in resident rooms #12, #13, #19 or #22 and agreed they all needed to be addressed. During an interview on 02/15/18 at 4:33 PM the Administrator stated he expected for staff to submit work orders to inform the MD of repairs that needed to be made. 2. a. Observations of resident bathroom #20 on 02/12/18 at 11:52 AM revealed the toilet tank lid was unsecure and too long to fit the tank. Additional observations on 02/13/18 at 5:16 PM and on 02/14/18 at 2:55 PM revealed the conditions remained unchanged. b. Observations of resident bathroom #21 on 02/12/18 at 11:54 AM revealed the baseboard next to the frame of the bathroom door was loose and peeled back from the wall. Additional observations on 02/13/18 at 5:18 PM and on 02/14/18 at 2:57 PM revealed the conditions remained unchanged. During an interview and environmental tour on 02/15/18 at 2:00 PM the MD revealed staff were expected to use the facility work order system to report repairs needed but would often inform him verbally. The MD explained he was the only employee in the maintenance department and would make repairs as they were noticed or reported. The MD confirmed he was not aware of the repairs needed in resident bathrooms #20 or #21 and agreed they both needed to be addressed. The MD explained he placed temporary toilet tank lids in several resident	F 584	on or before 3/19/18. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur: To ensure that this deficient practice does not recur, facility staff and contracted staff will be educated by the Administrator on or before 3/19/18 on the process for reporting maintenance issues including loose PTAC unit covers, non- fitting toilet tank covers, loose vented light covers, and missing or loose cove base. Education will also include the proper storage of clean linens and the need to keep the floors free of trash or other items. This education will include the designated staff members who participate in the Ambassador Program currently in effect at the facility. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: To ensure ongoing compliance, the Administrator or Director of Nursing will audit ten (10) resident rooms per week for four (4) weeks and monthly thereafter for two (2) months using an audit tool to determine if there are any loose PTAC unit covers, non- fitting toilet tank covers, loose vented light covers, and missing or loose cove base. In addition, the Housekeeping Manager will audit ten (10) linen closets per week for four (4) weeks and monthly thereafter for two (2) months	

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F 584	Continued From page 7 bathrooms after the originals were broken. He added he ordered new toilet tank lids but had not kept a list of the resident bathrooms that needed the replacements. During an interview on 02/15/18 at 4:33 PM the Administrator stated he expected for staff to submit work orders to inform the MD of repairs that needed to be made. 3. During the initial tour of the facility on 02/12/18 at 11:05 AM observations of the clean linen closet on the east wing revealed multiple linen and non-linen items on the floor of the closet. Items observed on the floor of the linen closet included a disposable diaper, multiple blankets, a pair of disposable gloves (turned inside out), 5 cloth incontinence pads, 2 open boxes of disposable gloves, a mechanical lift pad, a wadded-up section of toilet paper, sheets, a pillow and a comb. On 02/12/18 at 11:33 AM the condition of the linen closet was viewed with the Director of Nursing (DON) and she reported it was not acceptable. The DON stated it was the responsibility of laundry and housekeeping staff to keep the linen closet neat and clean. The DON stated she did not understand why a pair of disposable gloves and a section of toilet paper would be on the floor of the clean linen closet. Shortly thereafter staff were observed removing items that had been on the floor of the clean linen closet and the closet was detailed. On 02/16/18 at 5:55 PM the housekeeping manager stated she viewed the east wing linen closet on 02/12/18 (after informed of condition by	F 584	using an audit tool to determine if there any items improperly stored in the linen closets or trash items left on the floor. Any concerns identified will be brought to the Housekeeping Supervisor and Maintenance Director as appropriate for corrective action to be taken. Findings will be reported at the monthly QAPI meeting until such time substantial compliance has been achieved and the committee recommends quarterly oversight by the Administrator or designee to maintain compliance when completing clinical system reviews. This plan of correction will be implemented by the facility Administrator.	

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F 584	Continued From page 8 DON) and it was not acceptable. The housekeeping manager stated she expected the linen closet to be cleaned every day and could not explain what happened. The housekeeping manager stated she spoke to her staff that worked over the weekend and, though they reported the room was cluttered, they stated they did not notice items stored on the floor of the clean linen closet.	F 584		
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 assess 1 of 4 sampled residents utilizing the Minimum Data Set (MDS) reviewed for accidents (Resident #85) and 1 of 1 sampled residents reviewed for catheters (Resident #29). Findings included: 1. A review of an incident accident report dated 01/09/18 indicated Resident #85 had fallen in her room while attempting to transfer from the bed to the chair and was transferred to the emergency room. A review of an x-ray report dated 01/09/18 indicated Resident #85 had a hip fracture. A review of the Discharge Return Anticipated Minimum Data Set (MDS) assessment dated 01/10/18 indicated Resident #85 was discharged	F 641	F641 This alleged deficiency was caused by the facility Resident Care Management Director's (MDS Nurse) failure to accurately complete and code an assessment in accordance with the RAI manual. How will corrective action be accomplished for those residents found to have been affected by the deficient practice: Corrective action was accomplished for the alleged deficient practice for Resident #85 MDS with ARD of 1/21/18 to accurately reflect coding of Section A-most recent assessment, diagnosis of hip fracture and number of falls within the last month prior to admission/entry or reentry. Modification of this assessment was completed on 2/15/18. Resident # 29's	3/19/18

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F 641	Continued From page 9 to an acute hospital on 01/10/18. A review of the hospital discharge summary dated 01/14/18 indicated Resident #85 had a right hip fracture. Resident #85 was readmitted to the facility on 01/14/18 with diagnoses of right hip fracture. A review was conducted of Resident #85's significant change MDS assessment dated 01/21/18. Under Section A 0310E, the significant change MDS was not coded as the first assessment since the most recent admission/entry or reentry. Under Section I 3900, the MDS was not coded as having an active diagnoses of hip fracture. Under Section J 1700 the MDS had not been coded to reflect Resident #85 had a fall at any time in the last month prior to the admission/entry or reentry. On 02/15/18 at 3:19 PM an interview was conducted with MDS Coordinator #1 who stated he was responsible for coding Section A, I, and J of Resident #85's significant change MDS assessment dated 01/21/18. MDS Coordinator #1 stated he made an error and missed coding under Section A 0310E that the significant change MDS assessment dated 01/21/18 was Resident #85's most recent admission/entry or reentry assessment. Under Section I 3900 he missed coding that Resident #85 had an active diagnoses of hip fracture. Under Section J 1700 he missed coding that Resident #85 had fallen in the last month prior to admission/entry or reentry. MDS Coordinator #1 stated he would have to submit a modification to Resident #85's significant change MDS assessment dated 01/21/18 to indicate a correction under Section A	F 641	MDS ARD of 1/3/18 was corrected to accurately reflect coding of bladder continence. Modification of this assessment was also completed on 2/15/18. How will corrective action be accomplished for those residents having the potential to be affected by the same deficient practice: An audit of current residents having an indwelling catheter was completed by the Resident Care Management Director on 2/15/18 to verify accurate assessments of those residents bladder continence. An audit of current resident's 30 day look back was also completed by the Resident Care Management Director on 2/15/18 to verify Section A was coded accurately - most recent assessment, diagnosis coding of hip fracture and falls within the last month prior to admission/entry or reentry. Corrections were completed as identified per the RAI manual guidelines. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur: The District Director of Care Management (DDCM) re-educated the Resident Care Management Director (RCMD) and MDS coordinator on accurate MDS coding related to coding of bladder continence with residents having an indwelling catheter, Section A- most recent assessment, diagnosis coding of hip fracture and falls within the last month prior to admission/entry or reentry per the RAI manual. Education was completed	

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F 641	Continued From page 10 0310E, Section I 3900, and Section J 1700. On 02/15/18 at 3:39 PM an interview was conducted with the Director of Nursing (DON) who stated her expectations was that Resident #85's significant change MDS assessment dated 1/21/18 would have been accurately coded under Section A 0310E to reflect that the significant change assessment dated 1/21/18 was the most recent assessment. Under Section I to indicate Resident #85 had an active diagnoses of hip fracture. Under Section J 1700 to indicate that Resident #85 had fallen within the last month prior to admission/entry or reentry. The DON stated her expectation was that the significant change MDS assessment dated 1/21/18 would be modified and submitted to reflect a correction under Section A 0310E, Section I 3900, and Section J 1700. On 02/15/18 at 3:51 PM an interview was conducted with the Administrator who stated his expectation was that Resident #85's significant change MDS assessment dated 1/21/18 would have been accurately coded under Section A 0310E to reflect that the significant change assessment dated 1/21/18 was the most recent assessment. Under Section I to indicate Resident #85 had an active diagnoses of hip fracture. Under Section J 1700 to indicate that Resident #85 had fallen within the last month prior to admission/entry or reentry. The administrator stated his expectation was that the significant change MDS assessment dated 1/21/18 would be modified and submitted to reflect a correction under Section A 0310E, Section I 3900, and Section J 1700. 2. Resident #29 was admitted to the facility on	F 641	on 2/15/18. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The Resident Care Management Director's or Director of Nursing will randomly review 3 completed MDS's weekly for four (4) weeks and monthly thereafter for two (2) months to verify accurate coding of bladder continence with indwelling catheters, Section A- most recent assessment, diagnosis of hip fracture and falls within the last month prior to admission/entry or reentry. Any discrepancies noted will be corrected immediately as identified. The results of these audits will be reported at the monthly QAPI meeting until such time substantial compliance has been achieved and the committee recommends quarterly oversight by the Director of Clinical Services or designee to maintain compliance when completing Clinical Systems Review. The Director of Nursing is responsible for implementing the acceptable plan of correction.	

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F 641	Continued From page 11 3/18/17 with diagnoses including heart failure hypertension (high blood pressure), diabetes mellitus, and retention of urine. A quarterly Minimum Data Set (MDS) dated 1/3/18 indicated Resident #29 was coded under Section H Bladder and Bowel as having an indwelling catheter and as always being incontinent of urine. An observation of Resident #29 on 2/13/18 at 8:30 am revealed he had an indwelling catheter. An interview on 2/15/18 at 2:30 pm with MDS Nurse #1 revealed that Resident #29 did have an indwelling catheter and was not always incontinent of urine. MDS Nurse #1 stated that an error in coding had occurred and she would send in a correction. An interview on 2/15/18 at 3:30 pm with the Director of Nursing (DON) revealed that it was her expectation that the MDS be coded accurately and she expected a correction of the MDS to be completed. An interview on 2/15/18 at 4:30 pm with the Administrator revealed that it was his expectation that the MDS be coded accurately and he expected a correction of the MDS to be completed.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and	F 656		3/19/18

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F 656	Continued From page 12 §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to develop a	F 656	F656 This alleged deficiency was caused by the	

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F 656	Continued From page 13 comprehensive care plan for 1 of 1 sampled residents reviewed for enteric isolation precautions (Resident #87). The findings included: A Significant Change Minimum Data Set (MDS) dated 1/22/18 indicated Resident #87 was admitted to the facility 12/27/17 and was moderately impaired for cognition. Resident #87's diagnoses were coded as hypertension (high blood pressure), coronary artery disease (CAD), gastro-esophageal reflux disease (GERD), diabetes mellitus, thyroid disorder, Non-Alzheimer's Dementia, hemiplegia, depression, abnormal posture, dysphagia (difficulty swallowing), flaccid hemiplegia affecting the left side, clostridium difficile (abbreviated as C-diff and meaning a contagious infection of the bowel), and vitamin D deficiency. Resident #87 required extensive assistance with bed mobility, transfers, toileting, and personal hygiene. A record review of the Care Area Assessment (CAA) for pressure ulcers dated and signed by MDS Nurse #1 on 1/22/18 indicated Resident #87 had a current diagnosis of C-diff and had a significant decline in weight. The CAA also stated Resident #87 had returned from the hospital with two stage 3 pressure ulcers and two unstageable pressure ulcers. The CAA further indicated Resident #87 had been on antibiotic therapy for C-diff and continued on antibiotic therapy during the lookback period. Resident #87 was incontinent of bowel and bladder in the lookback period and required extensive assistance with perineal care. Resident #87 was at risk for further skin breakdown related to incontinence, hemiplegia, and lack of independent mobility.	F 656	facility Resident Care Management Director (MDS Nurse) failure to identify and develop a comprehensive care plan for a resident on enteric isolation precautions How will corrective action be accomplished for those residents found to have been affected by the deficient practice: A care plan for resident #87 for enteric precautions was developed on 2/16/18 by the Resident Care Management Director (MDS Nurse). How will corrective action be accomplished for those residents having the potential to be affected by the same deficient practice: An audit of other residents requiring enteric precautions was completed on 2/19/18 by the Resident Care Management Director (MDS Nurse) with no further issues identified. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur: To ensure the deficient practice does not recur, the Interdisciplinary Team (IDT) will be in- serviced on or before 3/19/18 by the Staff Development Coordinator, Resident Care Management Director (MDS Nurse), and/or Director of Nursing on the requirements of F566 with emphasis on facility development and implementation of comprehensive person-centered care	

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F 656	Continued From page 14 Care plans dated 2/2/18 included appropriate goals and interventions for impaired skin integrity and bowel incontinence. The care plans did not indicate that Resident #87 was on enteric isolation precautions for C-diff. Observation of Resident #87's room on 2/13/18 at 4:23 pm revealed a sign on the door indicating enteric isolation precautions were to be followed for any person entering the room. There was also a shelf on Resident #87's door that contained isolation gowns and gloves. Observation of Resident #87's room on 2/14/18 at 1:45 pm revealed the wound care practitioner and the wound care nurse entering the room with isolation gowns and gloves in place. An interview was conducted with MDS Nurse #1 on 2/16/18 at 11:30 am who stated that a care plan for C-diff for Resident #87 should have been in place and she overlooked initiating the care plan for C-diff. An interview with the Director of Nursing on 2/16/18 at 5:50 pm revealed it was her expectation that a resident with a diagnosis of C-diff have a care plan in place for C-diff. An interview with the Administrator on 2/16/18 at 5:54 pm revealed it was his expectation that a resident with a diagnosis of C-diff have a care plan in place for C-Diff.	F 656	plans for each resident, consistent with resident's rights and including measureable objectives, timeframes to meet a resident's medical, nursing, and mental and psychosocial needs. IDT members will enter focus, goals, and intervention tasks per the resident's care plan on or before 3/19/18. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: To ensure ongoing compliance, the Director of Nursing and Resident Care Management Director (MDS Nurse) will audit orders daily Monday through Friday to ensure that resident care plans are updated daily to reflect any new orders. Any discrepancies noted will be addressed immediately by the IDT and care plans updated. Results of these audits will be reported at the monthly QAPI meeting monthly for three (3) months or until such time substantial compliance has been achieved and the committee recommends quarterly oversight by the District Director of Clinical Services or designee to maintain compliance when completing clinical system reviews. The Director of Nursing is responsible for implementing the acceptable plan of correction.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		3/19/18

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F 677	Continued From page 15 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews, the facility failed to provide bathing assistance for 1 of 8 sampled residents who were dependent on staff for assistance with activities of daily living (Residents #138). Findings included: Resident #138 was admitted to the facility 02/05/18 with diagnoses which included traumatic amputation below the right knee, peripheral vascular disease, diabetes, depression, and pressure ulcer of the sacrum. The admission Minimum Data Set for Resident #138 dated 02/12/18 assessed him as cognitively intact and totally dependent on 2 staff for bathing. The Care Area Assessment associated with the admission MDS for the area of Activities of Daily Living (ADL) noted, Resident #138 requires assistance with all ADLs and staff to assist him with ADLs routinely and as needed. The nursing assistant care guide (the tool used by nursing assistants to know individual care needs of residents) indicated the shower days for Resident #138 were Monday and Friday on second shift. The admission care plan for Resident #138 dated 02/08/18 included the following problem areas: -Resident #138 is at high risk for falls related to	F 677	F677 This alleged deficiency was caused by Resident Care Specialist's (CNA) failure to follow established shower schedules. How will corrective action be accomplished for those residents found to have been affected by the deficient practice: Resident #138 was provided a shower on 2/16/18 by a Resident Care Specialist (CNA). Resident Care Specialists and Unit Coordinators will be provided in-service education by the Director of Nursing on following shower/bathing schedules on or before 3/19/18. How will corrective action be accomplished for those residents having the potential to be affected by the same deficient practice: An audit of resident shower schedules for each nursing unit will be completed by the Director of Nursing, Unit Coordinator(s) and Staff Scheduler on or before 3/19/18 to ensure showers, tub baths, and/or shampoos are scheduled at least twice weekly and more often as needed or requested. Any identified issues will be corrected immediately by the Unit Coordinators and/or Director of Nursing.	

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F 677	Continued From page 16	F 677		

amputation. Approaches to this problem area included to anticipate and meet the resident's needs.
-Resident #138 requires assistance with ADLs related to right below knee amputation and amputated toes on left foot. Approaches to this problem area included to provide assistance as required for completion of ADLs.
-Resident #138 has the potential/actual infection related to potential infection related to incontinence and recent right below knee amputation.

On 02/12/18 (Monday) at 03:08 PM Resident #138 stated he was admitted to the facility a week prior after an amputation of his right leg and was admitted for healing of the wound and to receive rehab services. Resident #138 was observed in bed and had an air mattress in operation on the bed. Resident #138 stated he had not been offered a bath or sponge bath since he had been at the facility and planned on requesting a bath because the air mattress generated so much heat he felt dirty and sweaty. Resident #138 stated he had not been told how baths/showers were provided and indicated he would not have declined one if offered. At the time of the interview the hair of Resident #138 appeared to be wet and greasy.

On 02/13/18 at 8:39 AM Resident #138 stated he requested a shower during second shift on 02/12/18 and was provided a bed bath and had his hair washed and noted he felt so much better. Resident #138 stated he was told his shower days were Monday and Friday during second shift. Resident #138 stated he was not offered a bed bath or shower on Friday, 02/09/18 and again stated he would not have declined had a bed bath

What measures will be put into place or systematic changes made to ensure the deficient practice does not recur:

Current Licensed Nurses and Resident Care Specialists will be educated by the Director of
Nursing, Staff Development Coordinator, RN Supervisor and/or Unit Coordinators on or before 3/19/18 regarding the requirements for compliance with F677-ADL Care, and that residents who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, and personal hygiene.

How the corrective actions will be monitored toEnsure the practice will not recur, i.e. what
Quality assurance program will be put into place:

To ensure ongoing compliance, Licensed Nurses and/or Unit Coordinators will verify that showers scheduled for the previous day are completed according to the shower schedule and resident choice using an audit tool daily for four (4) weeks, then three (3) times a week for four (4) weeks and then monthly for one (1) month or until compliance has been determined. Any identified discrepancies will be corrected immediately with re-education provided as necessary.

The results of these audits will be reported at the monthly QAPI meeting

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F 677	Continued From page 17 or shower been offered. Review of electronic documentation in the medical record of Resident #138 noted nursing assistant documentation which indicated bathing did not occur on 02/09/18 and noted 02/12/18 was the only time a bath/shower had been documented for Resident #138 since admission on 02/05/18. Review of all nursing progress notes in the medical record of Resident #138 did not address showers/bathing. On 02/14/18 at 3:45 PM nurse aide (NA) #1 that was working on east wing on Friday, 02/09/18 reported there were only two nursing assistants for the whole east wing on second shift and it was a challenge to get all the work done during the shift. NA #1 stated she could not recall any residents listed on the assignment sheet on 02/09/18 as needing a shower during second shift and if she had known Resident #138 wanted a shower during her shift, she could have provided that or a bed bath. On 02/16/18 at 5:25 PM the Director of Nursing (DON) stated she remembered Resident #138 refused therapy on 02/09/18 because he did not want to get out of bed. The DON stated his refusal to get out of bed did not mean he should not have been offered a bed bath. The DON stated she couldn't explain what happened and expected residents to get bathed as scheduled.	F 677	until such time substantial compliance has been achieved and the committee recommends quarterly oversight by the Director of Clinical Services or designee to maintain compliance when completing Clinical Systems Review. The Director of Nursing is responsible for implementing the acceptable plan of correction.	
F 689 SS=G	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	F 689		3/12/18

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F 689	Continued From page 18 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 medical record review, observations and interviews with residents and staff the facility failed to safely transfer one (1) of four (4) sampled dependent residents resulting in a fall and the resident experienced a fractured leg. (Resident #31) The findings included: Resident #31 was originally admitted to the facility 07/07/11 with diagnoses which included schizoaffective disorder/bipolar type, anxiety, depression, pseudobulbar affect, pain, multiple sclerosis and acute embolism and thrombosis in lower extremities. The last annual MDS dated 01/04/18 assessed Resident #31 as cognitively intact and requiring extensive assistance of two staff for transfers. The Care Area Assessment (CAA) associated with the 01/04/18 MDS included an assessment of Activity of Daily Living (ADL) function which noted, Resident requires assistance from staff to compete activities of daily living (ADLs), functional mobility and maintain dignity. Resident is able to communicate all needs. Resident has physical limitations due to multiple sclerosis and is non ambulatory. Transfers with a sit to stand lift with 2 staff. The CAA associated with the 01/04/18 MDS included an assessment of fall risk which noted, Resident is at risk for falls with injury. Resident has physical limitations due to	F 689	Past noncompliance: no plan of correction required.	

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multiple sclerosis and is non ambulatory. Transfers with sit to stand lift with 2 staff.

The current care plan for Resident #31 included problems which were originally initiated on 05/05/17 and last revised on 02/15/18 which included:
-Resident #31 has an ADL self care performance deficit related to multiple sclerosis , limited mobility on her own, requires staff assist with daily task of dressing and toileting with transfers related to multiple sclerosis diagnosis, poor safety awareness, medication use. Approaches to this problem area included resident requires supervision to total care with ADLs depending on medical status and function. Resident requires sit to stand mechanical lift and two person assist with transfers.
-Resident #31 is at risk for falls related to incontinence, psychoactive drug use, multiple sclerosis and history of falls. Approaches to this problem area included anticipate and meet the resident's needs.

A Fall Risk Assessment completed 01/25/18 for Resident #31 assessed a high risk for fall due to chair bound status, medication use and predisposing disease.

A Transfer Evaluation dated 01/25/18 for Resident #31 assessed a sit to stand lift as appropriate for transfers.

A Situation Background Assessment Request (SBAR) communication form and progress note in the medical record of Resident #31 dated 01/31/18 noted, "Resident was being transferred to bed when knees buckled with resident care specialist and resident fell to floor." The

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Interdisciplinary Post Fall Review dated 01/31/18 noted Resident #31 was transferred to acute care due to fracture of tibia and fibula.

Review of the medical record revealed Resident #31 was evaluated by the Nurse Practitioner after the 01/31/18 fall and an X-ray was ordered which revealed a closed fracture of the tibia and fibula. The Nurse Practitioner noted Resident #31 had little to no muscle tone in both legs due to multiple sclerosis and with suspected osteoporosis felt the folding of one leg on top of the other likely the method of fracture of the right tibia and fibula. Resident #31 was sent to the hospital and returned on 01/31/18 with a soft brace and diagnosis of fracture of right tibia and fibula.

The current quarterly Minimum Data Set (MDS) dated 02/05/18 assessed Resident #31 as cognitively intact and requiring extensive assistance of two staff for transfers.

On 02/15/18 at 9:00 AM the nurse aide (NA) #2 who was involved in the incident with Resident #31 on 01/31/18 stated she worked for a nursing agency and had worked at the facility a few times prior to 01/31/18. NA #2 stated she was aware the facility policy was to always have 2 staff present for mechanical lift transfers. NA #2 stated she was rushing to assist residents out of bed the morning of 01/31/18 and couldn't find another nursing assistant to assist her to transfer Resident #31 with the sit to stand lift. NA #2 stated the legs of Resident #31 buckled when she transferred Resident #31 by herself on 01/31/18 and she lowered Resident #31 to the floor. NA #2 stated she immediately went to get help and Resident #31 was assisted to the bed by two staff

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members and evaluated for injury by the Nurse Practitioner. After the incident the NA #2 stated she was called into the office of the Director of Nursing and then sent home.

On 02/15/18 at 11:45 AM the Director of Nursing (DON) stated it had always been the facility policy to use 2 staff for all mechanical transfers and to follow manufacturer directions when securing a resident in a lift. The DON stated this was reviewed with employees during orientation and with all agency staff (by the staffing agency) prior to working at the facility. The staffing schedule for 01/31/18 was reviewed with the DON and revealed adequate staffing on the hall where Resident #31 resided. The DON stated on 01/31/18 the nursing assistant care guide (a tool used to know individual resident care needs) noted Resident #31 required the assistance of 2 staff for transfers utilizing the sit to stand lift.

On 02/16/18 at 2:00 PM Resident #31 was interviewed. Resident #31 stated prior to 01/31/18 there had always been 2 staff present for transfers with the sit to stand lift. Resident #31 stated she reminded the NA #2 there were supposed to be 2 staff present for transfers and she "agreed to try" the transfer with only NA #2 present when the nursing assistant did not get another nursing assistant to help her with the transfer on 01/31/18. Resident #31 stated during the transfer her knees buckled, her right leg went toward the left leg and the nursing assistant lowered her to the ground. Resident #31 stated she was assisted back in the bed and the Nurse Practitioner assessed her for injury. Resident #31 stated her right leg was badly swollen so she knew something was wrong and later found out she had a broken tibia and fibula.

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Review of the facility investigation into the fall on 01/31/18 concluded the nursing assistant neglected to request the assistance of an additional staff member when transferring Resident #31 from bed to chair utilizing the sit to stand lift. As a result, Resident #31 had a fall which resulted in a fracture of the tibia and fibula. The investigation noted the nursing assistant knew she was supposed to have another staff member present during the transfer but got "in a hurry."

The facility's corrective actions implemented after the incident to prevent a reoccurrence included the following:

1. Resident #31 was assessed by the Nurse Practitioner on 01/31/18. An X-ray revealed a tibia and fibula fracture and Resident #31 was sent out to the hospital for evaluation and treatment. The nursing assistant that transferred Resident #31 independently on 01/31/18 was counseled on 01/31/18, sent home without completing her shift and a request was made to the staffing agency that she not return to the facility.

2. All nursing staff (licensed nurses and nursing assistants) were re-educated on resident transfers and proper procedure with a return demonstration. All agency nursing staff (licensed nurses and nursing assistants) were re-educated on resident transfers and proper procedure with a return demonstration (prior to working at the facility). All residents in the facility were re-assessed to determine the amount of assistance required for transfers including which lift to use. All nursing staff (licensed nurses and

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nursing assistants) were re-educated on where to locate the appropriate method of transfer for residents in the care guide (which contained individual care needs for residents) and individual care plans. The re-education and return demonstration began on 01/31/18 and was ongoing through the time of the survey (as new agency staff reported for duty.)

3. Quality improvement monitoring was initiated 02/04/18 after all training was completed to monitor 3 different mechanical lift transfers to ensure 2 person compliance plus 3 different staff interviews to ensure knowledge of mechanical lift protocol weekly for 4 weeks, then monthly until compliance was determined.

4. The results of the monitoring would be reported at the monthly Quality Assurance and Performance Improvement (QAPI) meeting until such time as substantial compliance had been achieved and the committee recommended oversight by the District Director of Clinical Services or designee to maintain compliance when completing clinical system reviews.

The facility's corrective actions were verified on 02/15/18-02/16/18 by record review, observations and interviews with residents and staff.

The record of Resident #31 was reviewed. Resident #31 was assessed by the Nurse Practitioner on 01/31/18. The physician and family member were informed of the incident and Resident #31 was immediately sent to the hospital for assessment and treatment.

The DON investigated the incident. The 24 hour and 5 day report were sent to the State Agency.

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The nursing assistant involved in the 01/31/18 incident was counseled and a request was made to the staffing agency for her not to be sent again to the facility.

In-service records were reviewed with training started on 01/31/18 and ongoing (as new agency staff reported for duty.) All staff signed attendance sheets with inservices addressing the sit to stand lift, sling lift and review of the neglect policy. A return demonstration of the sit to stand and sling lift was required by all staff (prior to start of work after 01/31/18). All newly hired employees, nursing staff and agency staff working since 01/31/18 had received training and a system was in place to ensure all new facility staff and agency staff were properly trained and demonstrated return demonstration on use of all lifts.

During the survey observations of staff transferring dependent residents utilizing the sit to stand and sling lift were made. Interviews were conducted with dependent residents regarding assistance provided by staff when utilizing lifts for transfers. No issues were identified with observations or interviews.

During the survey nurses and nursing assistants (both facility and agency staff) were interviewed and verified they received in-service on transferring residents with a lift with emphasis on always having two staff present. Nursing staff reported they had to demonstrate use of the lifts and that training also included neglect and reporting any unsafe acts or practices. Nursing assistants stated they reviewed the care guide before every shift to identify any changes with transfer requirements for residents they were

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F 689	Continued From page 25 assigned to care for. The DON reported since 01/31/18 there had been no reports of a nursing assistant transferring a resident independently with a lift. The monitoring tools were reviewed and included random checks of residents and staff from all shifts and in the time frames indicated. The monitoring was initiated 01/31/18 and was ongoing at the time of the survey. The 02/04/18 monitoring information revealed no concerns were identified.	F 689		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755		3/19/18

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F 755	Continued From page 26 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff, and physician interviews the facility failed to discard an opened HumaLOG insulin KwikPen that was expired for 17 days and was available for use in 1 of 3 medication carts. Findings included: A review of the manufacturer's recommendation for the storage and use of HumaLOG insulin KwikPen indicated the insulin had to be used within 28 days once the HumaLOG KwikPen was opened. A review of the facility's policy entitled Medication Storage in the Facility Storage of Medication Section 4.1 dated 05/12 indicated (in part) when the original seal of a manufacturer's container or vial was initially broken, the container or vial would be dated by the nurse. Resident #65 was admitted to the facility on 10/06/17 with a diagnosis of diabetes mellitus. A physician's order dated 10/25/17 indicated Resident #65 was to receive HumaLOG insulin KwikPen as per sliding scale before meals and at bedtime for diabetes mellitus.	F 755	F755 This alleged deficiency was caused by a Licensed Nurse failing to identify that a medication was expired before administering it to a resident. How will corrective action be accomplished for those residents found to have been affected by the deficient practice: The expired HumaLOG insulin KwikPen for resident #65 was immediately removed from the medication cart on 2/13/18 and replaced. The facility contracted Nurse Practitioner (NP) assessed resident #65 on 2/13/18 and wrote a new order to obtain two blood sugar readings for this resident. Both blood sugars tested were within normal limits. Current Licensed Nurses will be educated by the Director of Nursing, Staff Development Coordinator, RN Supervisor and/or Unit Coordinators on or before 3/19/18 regarding the requirements of F755 and that when the original seal of a drug manufacturer’s container or vial is initially broken, the container or vial will be dated with the date opened and with an expiration date. The expiration date of the	

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F 755	Continued From page 27 On 02/13/18 at 11:33 AM Resident #65's HumaLOG insulin KwikPen was observed on the Alzheimer Care Unit (ACU) medication cart ready for use and was opened and dated 12/30/17. On 02/13/18 at 11:38 AM an interview was conducted with Nurse #1 who stated insulin was dated when it was opened and verified that Resident #65's HumaLOG insulin KwikPen was dated 12/30/17. Nurse #1 stated at 11:30 AM she had used the HumaLOG insulin KwikPen dated 12/30/17 to administer 2 units of HumaLOG insulin as per sliding scale to Resident #65. Nurse #1 stated she was unaware of an expiration date for the HumaLOG insulin KwikPen that was dated 12/30/17. Nurse #1 immediately called the pharmacy and then indicated that Resident #65's HumaLOG insulin KwikPen dated 12/30/17 had expired because it was good for 28 days after it had been opened. A review of the Medication Administration Record (MAR) revealed Resident #65 received 2 units of HumaLOG insulin on 02/13/18 at 11:30 AM as indicated by Nurse #1's documentation on the MAR. On 02/13/18 at 11:50 AM an interview was conducted with the Director of Nursing (DON) who stated her expectation was that Nurse #1 would not have administered expired HumaLOG insulin KwikPen to Resident #65. The DON stated her expectation was that Nurse #1 would have called the pharmacy to verify the expiration date on the HumaLOG insulin KwikPen prior to administering the insulin to Resident #65. The DON stated HumaLOG insulin KwikPen was good for 28 days after it had been opened and verified Resident #65's HumaLOG insulin was	F 755	vial or container will be thirty (30) days from opening unless the manufacture's recommendation or other regulation guideline provides for a different expiration date. How will corrective action be accomplished for those residents having the potential to be affected by the same deficient practice: Medication cart audits throughout the facility were completed by Unit Coordinators on 2/13/18 with dating issues corrected as identified. No other expired HumaLog insulin was discovered during these audits. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur: Current Licensed Nurses will be educated by the Director of Nursing, Staff Development Coordinator, RN Supervisor and/or Unit Coordinators on or before 3/19/18 regarding the requirements of F755 and that when the original seal of a drug manufacturer's container or vial is initially broken, the container or vial will be dated with the date opened and with an expiration date. The expiration date of the vial or container will be thirty (30) days from opening unless the manufacture's recommendation or other regulation guideline provides for a different expiration date. How the corrective actions(s) will be	

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F 755	Continued From page 28 dated 12/30/17 and was expired. On 02/13/18 at 12:53 PM a telephone interview was conducted with the physician who stated his expectation was that Resident #65 would not have received expired HumaLOG insulin. He stated his expectation was that the medication cart would have been checked for expired medication prior to Resident #65 receiving expired HumaLOG insulin. His expectation was that the nurse would have verified that the HumaLOG insulin KwikPen had expired prior to administering insulin to Resident #65. The physician stated he did not believe that Resident #65 would have experienced an adverse outcome form receiving the expired HumaLOG insulin. On 02/13/18 at 1:31 PM an interview was conducted with the Administrator who stated his expectation was that Resident #65 would not have received expired HumaLOG insulin KwikPen. The administrator stated his expectation was that Nurse #1 would have checked the expiration date on the insulin prior to administering the HumaLOG insulin to Resident #65.	F 755	monitored to ensure the practice will not recur, i.e. what quality assurance program will be put into place: To ensure ongoing compliance, Licenses Nurses will audit medication carts for expired medications daily for four (4) weeks, then three (3) times a week for four (4) weeks and then monthly for one (1) month or until compliance has been determined. Findings will be reported to the monthly QAPI meeting until such time substantial compliance has been achieved and the committee recommends quarterly oversight by the District Director of Clinical Services or designee to maintain compliance when completing Clinical System reviews. The Director of Nursing is responsible for implementing the acceptable plan of correction.	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or	F 757		3/19/18

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F 757	Continued From page 29 §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to obtain a lab test for 1 of 5 sampled residents with medications reviewed. (Resident #67) The findings included: Resident #67 was admitted to the facility 03/23/16 with diagnoses which included heart failure, diabetes, depression, difficulty walking, panic disorder, anxiety, hypertension and hyperlipidemia. The current care plan for Resident #67 last updated 12/05/17 included: -Resident #67 has impaired cardiovascular status related to hypertension and hyperlipidemia. Approaches to this problem area included labs as ordered. Review of current physician orders noted medications taken by Resident #67 included 80 milligrams (mg) of Lasix (a diuretic) every morning.	F 757	F757 This alleged deficiency was caused by a Licensed Nurse failing to transcribe an order to recheck a potassium level. How will corrective action be accomplished for those residents found to have been affected by the deficient practice: The potassium blood draw order for Resident #67 was discontinued by the facility contracted Nurse Practioner (NP) on 3/8/18. This resident's attending physician examined her on 2/26/18 with no new lab tests ordered. How will corrective action be accomplished for those residents having the potential to be affected by the same deficient practice: An audit of lab tests ordered within the past sixty (60) days for current residents	

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F 757	Continued From page 30 Review of physician progress notes in the medical record of Resident #67 included a progress note dated 12/08/17 which read in part, Recent chest X-ray suggestive of congestive heart failure, Lasix has doubled to 80 mg twice a day. Review of the December 2017 and January 2018 Medication Administration Record (MAR) of Resident #67 noted administration of 80 mg of Lasix twice a day from 12/08/17-01/02/18 and from 01/05/18-01/26/18. Review of lab work in the medical record of Resident #67 noted a potassium level on 01/10/18 of 2.9 with the normal range of 3.6-5.0. At the time of the 01/10/18 lab, Resident #67 was receiving 20 milliequivalents (meq) of potassium every day. On 01/10/18 a physician's order was written to give 40 meq of potassium every 8 hours for three days and to recheck the potassium level on 01/11/18. On 01/11/18 the potassium level was 3.7 and the physician ordered to administer 40 meq of potassium every day. On 01/19/18 a physician's order was written to recheck the potassium level of Resident #67. The 01/19/18 potassium level for Resident #67 was 3.2 and the physician wrote an order for 20 meq of potassium for three days and to recheck the potassium in one week. Review of the medical record of Resident #67 revealed no potassium levels since 01/19/18 and, review of the January 2018 MAR noted the last time potassium was administered to Resident #67 was 01/23/18. Resident #67 was seen by the nurse practitioner on 01/26/18 due to hyperglycemia and changes were made to medications including the dosage	F 757	will be completed by the Unit Coordinators or RN Supervisor, or Director of Nursing on or before 3/19/18 to ensure lab orders have been noted, requested, scheduled, and obtained . Any identified issues will be corrected immediately by the Unit Coordinators, RN Supervisor and/or Director of Nursing. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur: Licensed Nurses will be educated by the Director of Nursing, Staff Development Coordinator and/or Unit Coordinators on or before 3/19/18 regarding the requirements for compliance with F757 with emphasis on unnecessary drugs – general. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug used without adequate monitoring. How the corrective actions(s) will be monitored to ensure the practice will not recur, i.e. what quality assurance program will be put into place: To ensure ongoing compliance, the 3rd shift (11PM- 7 AM) Licensed Nurses will complete chart audits for review of lab orders to ensure timely notation and scheduling of lab orders daily using an audit tool for four (4) weeks, then three (3) times a week for four (4) weeks and then monthly for one (1) month or until compliance has been determined. Any identified issues will be corrected	

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F 757	Continued From page 31	F 757		

of Lasix was decreased from 80 mg twice a day to 80 mg once a day. The nurse practitioner's progress note did not address the 01/19/18 order for the potassium lab.

On 02/16/18 at 11:30 AM the lab was called about the follow-up potassium level for Resident #67 which was ordered on 01/19/18 and due 01/26/18. The lab technician reported they did not receive an order to check the potassium for Resident #67 so it was not done.

On 02/16/18 at 11:45 AM the unit coordinator (on the unit Resident #67 resided) reviewed the lab book which the facility utilized to record orders for labs. After review of the book, the unit coordinator stated the order had not been transcribed in the lab book which was why a requisition for the lab order was not completed. Nurse #3, that noted the 01/19/18 order for Resident #67 was present at the time of the interview (with the unit coordinator) and stated she could not explain why the 01/19/18 order for the follow-up potassium level for Resident #67 had not been placed on the lab book.

On 02/16/18 at 3:00 PM the physician of Resident #67 stated he expected labs to be done as ordered. The physician stated the follow-up lab would have been utilized to assess if Resident #67 needed potassium supplementation. The physician stated he did not feel there was any harm to Resident #67 because she was not having chest pain or tachycardia which might be an issue if a resident had lower potassium levels.

On 2/16/18 at 5:20 PM the Director of Nursing (DON) stated she expected lab work to be done as ordered by the physician. The DON stated

immediately by the licensed nurse.

Unit Coordinators will perform review of chart audits for accurate processing of lab orders daily, Monday through Friday, for four (4) weeks, then three (3) times a week for four (4) weeks and then monthly for one (1) month or until compliance has been determined. Any discrepancies identified will be corrected immediately with re-education provided as necessary.

Findings will be reported to the monthly QAPI meeting until such time substantial compliance has been achieved and the committee recommends quarterly oversight by the District Director of Clinical Services or designee to maintain compliance when completing Clinical System reviews.

The Director of Nursing is responsible for implementing the acceptable plan of correction.

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F 757	Continued From page 32 she expected the nurse that noted an order for lab work would transcribe the order in the lab book. The DON stated the 01/19/18 order for a potassium level for Resident #67 was not done as ordered because the order was not transcribed in the lab book by Nurse #3.	F 757		
F 812 SS=E	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 a dietary employee failed to wash hands between handling soiled dishware and clean dishware and the facility failed to clean an ice scoop holder located on the ice machine in the activity room. The findings included:	F 812	F812 This deficiency was caused by staff members failure to follow established policies and procedures related to hand washing and infection control procedures, and process failure related to the routine cleaning of an ice scoop and its holder.	3/19/18

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F 812	Continued From page 33 1. During the initial tour of the facility kitchen on 02/12/18 from 9:50 AM-10:20 AM 2 dietary aides were observed working at the dish machine. One employee (Dietary Aide #1) was removing soiled trays from a cart, discarding any uneaten food and placing the dishware at the soiled section of the dish machine. The second aide (Dietary Aide #2) was standing in the vicinity of the dish machine. The following continuous observations were made of Dietary Aide #2 standing at the dish machine: -Dietary Aide #2 placed a hair net on her head and, without washing her hands, removed clean dishes from a rack and placed them in clean storage. -Dietary Aide #2 placed dirty dishes on a rack and placed the rack in the dish machine. Dietary Aide #2 did not wash her hands and proceeded to remove clean dishes from a rack and placed them in clean storage. -Dietary Aide #2 donned a pair of gloves on her hands (was not wearing gloves for first two observations) and placed dirty dishes on a rack, pulled a rack of clean dishes out of the dish machine, placed dirty dishes on a rack then pulled another rack of clean dishes out of the dish machine. -The Food Service Director (FSD) came to the dish machine area at this point and was present when Dietary Aide #2 went to a hand sink, turned the water on with the gloved hands, ran her hands under the water (no soap or sanitizer used), turned the water off with the gloved hands and picked up a wet rag (stored beside the sink) to wipe her hands. Dietary Aide #2 then removed clean dishes from a rack and placed them in clean storage. -Dietary Aide #2 placed dirty dishes on a rack and placed the rack in the dish machine and	F 812	How will corrective action be accomplished for those residents found to have been affected by the deficient practice: Dietary Aide #2 was educated by the Dietary Manager and District Dietary Manager on 2/12/18 on the proper procedures for hand washing following application of a hair net and between handling of dirty and clean dishes, and the proper use and changing of gloves. Other kitchen staff were also educated by the Dietary Manager and District Dietary Manager on these requirements on 2/12/18. The ice scoop and its holder mounted on the activity room ice machine were discarded and replaced with new ones on 2/13/18. The new ice scoop holder is removable from its mount to allow for easy removal and cleaning. How will corrective action be accomplished for those residents having the potential to be affected by the same deficient practice: Dietary Aide #2 was educated by the Dietary Manager and District Dietary Manager on 2/12/18 on the proper procedures for hand washing following application of a hair net and between handling of dirty and clean dishes, and the proper use and changing of gloves. Other kitchen staff were also educated by the Dietary Manager and District Dietary	

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proceeded to remove clean dishes from a rack and placed them in clean storage. The aide sneezed in to her arm and continued to remove clean dishes from a rack and placed them in clean storage (without washing her hands.)

The FSD was asked about the observed dish washing practices of Dietary Aide #2 and the FSD stated the aide should wash hands between touching dirty and clean dishware, after putting on a hairnet and after sneezing into her hand.

On 02/12/18 at 2:00 PM the FSD stated Dietary Aide #2 had been trained on proper dish washing practices and Dietary Aide #2 stated she felt "under pressure" and made a mistake when working at the dish machine that morning.

2. On 02/12/18 at 11:40 AM a clear ice scoop holder was observed attached to the ice machine in the activity room. The ice scoop holder had 2 holes at the top of the clear plastic holder and hung from 2 screws which were mounted to the ice machine. An ice scoop was stored inside the ice scoop holder with the scoop portion touching the interior bottom of the holder. The interior of the ice scoop holder appeared dirty and, when the inside portion was felt, it had a slimy feel. The activity director was present at the time of the observation and stated she was not aware who cleaned the ice scoop and holder. The activity director attempted to remove the ice scoop holder from the machine but, because one of the screws was bigger than the hole, the holder could not be removed. At 11:47 AM the staffing scheduler came to the activity room and stated she did not know who was responsible for cleaning the ice scoop holder. The staff scheduler was able to pry the ice scoop holder off the machine though it

Manager on these requirements on 2/12/18. A new soap dispenser and paper towel dispenser were installed in the dish machine area on 3/9/18 to provide easier access for staff to wash hands.

Other ice scoops and holders located in the main kitchen and on the hydration carts were inspected for cleanliness on 2/12/18 with no problems noted.

What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur:

To ensure that this deficient practice does not recur, dietary staff will observe proper hand washing and sanitation procedures and remove and clean the ice scoops and holders daily and document on a log when completed. Education on these procedures will be completed by the Dietary Manager on or before 3/14/18.

How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:

To ensure ongoing compliance, the Dietary Manager or designee will observe dietary staff practices related to hand washing and the handling of clean and dirty dishes five (5) times per week for four 4 weeks and monthly thereafter for two (2) months using an audit tool/ staff competency checklist. The Dietary Manager or designee will also inspect ice scoops and holders for cleanliness five (5)

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F 812	Continued From page 35 resulted in a crack in the holder (on the side where the screw was bigger than the hole.) At the same time a nursing assistant came to the activity room with an ice chest and stated she always used the ice scoop (stored inside the holder) to replenish ice for distribution to residents. On 02/14/18 at 1:07 PM the Food Service Director stated she was dependent on staff to bring the ice scoop and ice scoop holder from the activity room to the kitchen for cleaning. On 02/16/18 at 8:00 AM the maintenance director stated he cleaned the filters of the ice machine in the activity room and was not responsible for removing the ice scoop holder for cleaning. On 2/16/18 at 5:00 PM the Director of Nursing stated dietary staff was responsible for removing the ice scoop holder and taking it to the kitchen for cleaning. On 2/16/18 at 7:00 PM the Administrator stated there had been confusion over the activity room ice scoop holder and who was responsible for taking it to the kitchen for cleaning. The Administrator stated he expected the ice scoop holder to be cleaned and sanitized.	F 812	times per week for four 4 weeks and monthly thereafter for two (2) months using an audit tool. Any non- compliance noted will be corrected and staff re-educated as necessary concerns identified will be brought to the Housekeeping Supervisor and Maintenance Director as appropriate for corrective action to be taken. Findings will be reported at the monthly QAPI meeting until such time substantial compliance has been achieved and the committee recommends quarterly oversight by the Administrator or designee to maintain compliance when completing clinical system reviews. This plan of correction will be implemented by the facility Administrator.	
F 867 SS=G	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;	F 867		3/19/18

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F 867	Continued From page 36 This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and resident and staff interviews the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions that the committee had previously put into place. This failure related to four recited deficiencies that were originally cited following the 06/28/17 federal dementia survey, recited following the 11/02/17 complaint investigation and recited again on the current recertification and complaint investigation survey. The recited deficiencies were in the areas of safe/clean/comfortable/homelike environment, develop/implement comprehensive care plans, free of accident hazards/supervision/devices, and drug regimen is free from unnecessary drugs. The continued failure of the facility during three federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referenced to: 1. a. 483.10 Safe/Clean/Comfortable/Homelike Environment: Based on observations and staff interviews, the facility failed to secure loose heating/air conditioning covers and failed to repair a vented light cover that had come loose from the wall in 4 of 13 resident rooms (Rooms #12, #13, #19 and #22). The facility also failed to replace a toilet tank lid that was unsecured and too long to fit the tank and failed to repair baseboard that had peeled back from the wall in 2 of 7 resident bathrooms (Rooms #20 and #21). In addition, the facility failed to maintain clean and sanitary linen closets on 1 of 2 resident hallways (East	F 867	F867 This deficiency was caused by failure to sustain compliance through ongoing monitoring with four previously cited deficiencies; safe/clean/comfortable homelike environment, develop/ implement comprehensive care plans, free of accident hazards/supervision/devices, and drug regiment free from unnecessary drugs. F584 This alleged deficiency was caused by staff members failure to follow established policies and procedures related to maintaining clean linen rooms and routinely inspecting resident rooms and reporting necessary maintenance issues. How will corrective action be accomplished for those residents found to have been affected by the deficient practice: The heating/ air conditioning (PTAC) unit covers in rooms 12, 19 and 22 were adjusted and secured to the units by the Maintenance Director on 2/15/18. The loose vented light cover in room 13 was repaired and secured to the wall by the Maintenance Director on 2/15/18. The toilet tank cover in room 20 was replaced by the Maintenance Director on 2/15/18. The loose cove base in the bathroom of room 21 was repaired by the Maintenance	

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F 867	Continued From page 37 hall). During the complaint investigation of 11/2/17 the facility was cited for failure to repair a metal bracket with sharp edges on the lower half of the main dining room door, repair wood edging that was splintered and broken on the dining room doorway, repair broken and splintered laminate and wood on resident bedroom doors and shower room doors, repair broken and stained thresholds on resident room doorways, and replace a missing threshold in a resident bathroom doorway. b. 483.20 Develop/Implement Comprehensive Care Plan: Based on observations, record review, and staff interviews the facility failed to develop a comprehensive care plan for 1 of 1 sampled residents reviewed for enteric isolation precautions (Resident #87). During the federal dementia survey of 06/28/17 the facility was cited for failure to develop comprehensive plans of care to meet the residents' individualized needs. c. 483.25 Free of Accident Hazards/Supervision/Devices: Based on medical record review, observations and interviews with residents and staff the facility failed to safely transfer one (1) of four (4) sampled dependent residents resulting in a fall and the resident experienced a fractured leg. (Resident #31). During the federal dementia survey of 06/28/17 the facility was cited for failure to implement measures to protect female residents on the secured Alzheimer's unit from unwanted sexually inappropriate behavior, failure to provide	F 867	Director on 2/15/18. The East Wing linen closet was cleaned and organized on 2/12/18 by housekeeping and the disposable diaper, disposable gloves, open boxes of gloves, toilet paper, and comb on the floor were all discarded. The blankets, cloth incontinence pads, mechanical lift pad, and pillow were all sent to laundry and were cleaned. How will corrective action be accomplished for those residents having the potential to be affected by the same deficient practice: An inspection of other resident rooms and clean linen closets was completed by the Administrator, Maintenance Director, and Housekeeping Supervisor on 3/6/18 to determine if there were other loose PTAC unit covers, non- fitting toilet tank covers, loose vented light covers, and missing or loose cove base. Those identified will be repaired or replaced as necessary by the Maintenance Director, or other contractor on or before 3/19/18. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur: To ensure that this deficient practice does not recur, facility staff and contracted staff will be educated by the Administrator on or before 3/19/18 on the process for reporting maintenance issues including loose PTAC unit covers, non- fitting toilet	

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F 867	Continued From page 38 supervision to assure other residents were not exposed to sexually inappropriate behavior and failure to provide supervision to prevent resident to resident altercations. During the complaint investigation of 11/02/17 the facility was cited for the failure to transfer a resident with a mechanical lift who was at risk for falls. d. 483.45 Drug Regimen is Free from Unnecessary Drugs: Based on medical record review and staff interviews the facility failed to obtain a lab test for 1 of 5 sampled residents with medications reviewed (Resident #67). During the federal dementia survey of 06/28/17 the facility was cited for failure to assure residents were not administered antipsychotics without indications for use of the medication, failure to provide monitoring which justified the use of the medication and failure to attempt non-pharmacological interventions prior to the use of medications. During an interview on 02/13/18 at 7:25 PM the Administrator stated after the dementia survey and complaint investigation the QAA met to review the areas of concern, repairs were made and systems were put into place to correct the deficiencies cited. He explained the Minimum Data Set Coordinator was new and just missed developing a care plan for isolation precautions. The Administrator added the repeated areas of concern would be reviewed by the QAA committee and a performance improvement plan would be developed to correct the deficiencies.	F 867	tank covers, loose vented light covers, and missing or loose cove base. Education will also include the proper storage of clean linens and the need to keep the floors free of trash or other items. This education will include the designated staff members who participate in the Ambassador Program currently in effect at the facility. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: To ensure ongoing compliance, the Administrator or Director of Nursing will audit ten (10) resident rooms per week for four (4) weeks and monthly thereafter for two (2) months using an audit tool to determine if there are any loose PTAC unit covers, non- fitting toilet tank covers, loose vented light covers, and missing or loose cove base. In addition, the Housekeeping Manager will audit ten (10) linen closets per week for four (4) weeks and monthly thereafter for two (2) months using an audit tool to determine if there any items improperly stored in the linen closets or trash items left on the floor. Any concerns identified will be brought to the Housekeeping Supervisor and Maintenance Director as appropriate for corrective action to be taken. Findings will be reported at the monthly QAPI meeting until such time substantial compliance has been achieved and the committee recommends quarterly	

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oversight by the Administrator or designee to maintain compliance when completing clinical system reviews.

F656

This alleged deficiency was caused by the facility Resident Care Management Director (MDS Nurse) failure to identify and develop a comprehensive care plan for a resident on enteric isolation precautions

How will corrective action be accomplished for those residents found to have been affected by the deficient practice:

A care plan for resident #87 for enteric precautions was developed on 2/16/18 by the Resident Care Management Director (MDS Nurse).

How will corrective action be accomplished for those residents having the potential to be affected by the same deficient practice:

An audit of other residents requiring enteric precautions was completed on 2/19/18 by the Resident Care Management Director (MDS Nurse) with no further issues identified.

What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur:

To ensure the deficient practice does not

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F 867	Continued From page 40	F 867	recur, the Interdisciplinary Team (IDT) will be in- serviced on or before 3/19/18 by the Staff Development Coordinator, Resident Care Management Director (MDS Nurse), and/or Director of Nursing on the requirements of F656 with emphasis on facility development and implementation of comprehensive person-centered care plans for each resident, consistent with resident's rights and including measureable objectives, timeframes to meet a resident's medical, nursing, and mental and psychosocial needs. IDT members will enter focus, goals, and intervention tasks per the resident's care plan on or before 3/19/18. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: To ensure ongoing compliance, the Director of Nursing and Resident Care Management Director (MDS Nurse) will audit orders daily, Monday through Friday, for four (4) weeks, then three (3) times a week for four (4) weeks and then monthly for one (1) month or until compliance has been determined to ensure that resident care plans are updated daily to reflect any new orders. Any discrepancies noted will be addressed immediately by the IDT and care plans updated. Results of these audits will be reported at the monthly QAPI meeting monthly for three (3) months or until such time substantial compliance has been	

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achieved and the committee recommends quarterly oversight by the District Director of Clinical Services or designee to maintain compliance when completing clinical system reviews.

F689

How will corrective action be accomplished for those residents found to have been affected by the deficient practice:

On 1/31/18, resident #31 was safeguarded by staff and the physician and family were notified of the event. The facility nurse practitioner performed a bedside evaluation and an order was received for a stat x-ray of the right leg. Upon receiving results, the resident was transferred to the hospital per physician order for evaluation and treatment of right tibia and fibula fractures. Upon immediate interview, the agency CNA assigned to the resident was sent home and the agency notified that she not return to the facility.

How will corrective action be accomplished for those residents having the potential to be affected by the same deficient practice:

On 1/31/18, a house-wide audit of staff compliance with mechanical lifts was completed by the SDC. No other issues were identified.

What measures will be put into place or systemic changes made to ensure the

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F 867	Continued From page 42	F 867	deficient practice does not recur: Beginning on 1/31/18, nursing staff were re-educated on mechanical lift use and proper transfer procedures with return demonstration. This education included standards of care per the individual care planned interventions. Prior to working assignments in the facility, newly hired staff/newly assigned agency staff will be educated on the policy and procedure for mechanical lift use. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The Director of Nursing /designee will randomly monitor corrective actions to ensure the effectiveness of these actions by randomly observing three (3) different mechanical lift transfers to ensure 2 person compliance plus three (3) different staff interviews to ensure knowledge of mechanical lift protocol weekly for four (4) weeks, then monthly until compliance has been determined. Findings will be reported at the monthly QAPI meeting until such time as substantial compliance has been achieved and the committee recommends quarterly oversight by the District Director of Clinical Services or designee to maintain compliance when completing clinical system reviews.	

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F 867	Continued From page 43	F 867	F757 This alleged deficiency was caused by a Licensed Nurse failing to transcribe an order to recheck a potassium level. How will corrective action be accomplished for those residents found to have been affected by the deficient practice: The potassium blood draw order for Resident #67 was discontinued by the facility contracted Nurse Practioner (NP) on 3/8/18. This resident's attending physician examined her on 2/26/18 with no new lab tests ordered. How will corrective action be accomplished for those residents having the potential to be affected by the same deficient practice: An audit of lab tests ordered within the past sixty (60) days for current residents will be completed by the Unit Coordinators or RN Supervisor, or Director of Nursing on or before 3/19/18 to ensure lab orders have been noted, requested, scheduled, and obtained . Any identified issues will be corrected immediately by the Unit Coordinators, RN Supervisor and/or Director of Nursing. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur: Licensed Nurses will be educated by the	

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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 867	Continued From page 44	F 867	Director of Nursing, Staff Development Coordinator and/or Unit Coordinators on or before 3/19/18 regarding the requirements for compliance with F757 with emphasis on unnecessary drugs – general. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug used without adequate monitoring. How the corrective actions(s) will be monitored to ensure the practice will not recur, i.e. what quality assurance program will be put into place: To ensure ongoing compliance, the 3rd shift (11PM- 7 AM) Licensed Nurses will complete chart audits for review of lab orders to ensure timely notation and scheduling of lab orders daily using an audit tool for four (4) weeks, then three (3) times a week for four (4) weeks and then monthly for one (1) month or until compliance has been determined. Any identified issues will be corrected immediately by the licensed nurse. Unit Coordinators will perform review of chart audits for accurate processing of lab orders daily, Monday through Friday, for four (4) weeks, then three (3) times a week for four (4) weeks and then monthly for one (1) month or until compliance has been determined. Any discrepancies identified will be corrected immediately with re-education provided as necessary. Findings will be reported to the monthly QAPI meeting until such time substantial	

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F 867	Continued From page 45	F 867	compliance has been achieved and the committee recommends quarterly oversight by the District Director of Clinical Services or designee to maintain compliance when completing Clinical System reviews. This plan of correction will be implemented by the facility Administrator. QAPI meetings will continue to be held monthly in accordance with the facility's current policy and procedures. Organizational performance measures relative to clinical and non- clinical data/ indicators will be reviewed, opportunities for improvement identified, and performance improvement plans developed. To ensure that quality improvement initiatives and plans of correction for the four repeat deficiencies noted above are sustained, additional audits will be completed the month following completion of the monitoring outlined above as follows: A facility inspection of other resident rooms and clean linen closets will be completed by the Administrator, Maintenance Director, and Housekeeping Supervisor to determine if there are any other loose PTAC unit covers, non- fitting toilet tank covers, loose vented light covers, and missing or loose cove base. A house wide audit of any residents requiring enteric precautions will be completed by the Resident Care	

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F 867	Continued From page 46	F 867	Management Director (MDS Nurse) to ensure that any identified are care planned accordingly. A house-wide audit of staff compliance with mechanical lifts will be completed by the SDC, RN Supervisor, Unit Coordinators/ Unit Managers, or Director of Nursing. An audit of lab tests ordered within the previous sixty (60) days for current residents will be completed by the Unit Coordinators/ Unit Managers, RN Supervisor, or Director of Nursing to ensure lab orders have been noted, requested, scheduled, and obtained. Any deficient practices noted during these additional audits will be referred to the QAPI Committee and revisions to the QAPI plans made as necessary. Findings will be reported at the monthly QAPI meeting until such time as substantial compliance has been achieved and the committee recommends quarterly oversight by the District Director of Clinical Services or designee to maintain compliance when completing clinical system reviews. This plan of correction will be implemented by the facility Administrator.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		3/19/18

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F 880	Continued From page 47	F 880		

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:
(A) The type and duration of the isolation, depending upon the infectious agent or organism

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F 880	Continued From page 48 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 observations, record review, and physician and staff interviews the facility failed to follow enteric isolation precautions for 1 of 1 residents (Resident #87) reviewed for infection control. The findings included: A Significant Change Minimum Data Set (MDS) for Resident #87 dated 1/22/18 coded the resident as having the following diagnoses: hypertension (high blood pressure), diabetes mellitus, Non-Alzheimer's Dementia, depression, clostridium difficile (abbreviated as C-diff and	F 880	F880 This alleged deficiency was caused by staff failure to understand and follow enteric isolation precautions using appropriate personal protective equipment (PPE). How will corrective action be accomplished for those residents found to have been affected by the deficient practice: Education was provided to the facility Staff	

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F 880	Continued From page 49 meaning a contagious bowel infection), and vitamin D deficiency. A review of Resident #87's chart revealed her stool culture report was identified as being C-diff positive in 1/1/18. An observation on 2/13/18 at 4:23 pm of Resident #87's door revealed a sign indicating the resident was on enteric isolation precautions and there was a shelf on the resident's door with isolation gowns and gloves. An observation on 2/15/18 at 8:20 am revealed the facility's infection control nurse and a nurse aide (NA) coming out of Resident #87's shared bathroom with no isolation gowns or gloves in place. Resident#87's breakfast tray was in her room on her over-bed table with the lid off. After exiting the resident's bathroom the infection control nurse left the room and the NA donned an isolation gown and gloves and sat down to feed the resident. An interview on 2/15/18 at 8:25 am with the infection control nurse revealed that she was educating the NA on enteric precaution isolation procedures even though the enteric isolation precautions sign on the door stated to perform hand hygiene before entering the room and to gown and glove before entering the room. The infection control nurse stated she and the NA had gone into the bathroom to wash their hands. The infection control nurse was unable to provide an answer as to why she and the NA were in Resident #87's room with no isolation gowns or gloves in place and why they had not washed their hands before entering the room. The infection control nurse stated the procedure for	F 880	Development Coordinator and Unit Coordinator by the Area Staff Development Coordinator on 2/15/18 regarding enteric precautions and proper procedures for entering the room. The facility Staff Development Coordinator then provided this education to Resident Care Specialists and other staff on 2/15/18. How will corrective action be accomplished for those residents having the potential to be affected by the same deficient practice: Observations of staff interaction with other residents on enteric precautions were completed by the facility Staff Development Coordinator, Unit Coordinator, and Director of Nursing on 2/15/18. No other observations of the same alleged deficient practice were noted. What measures will be put into place or systematic changes made to ensure the deficient practice does not recur: Other current staff, including Licensed Nurses, Resident Care Specialists, Housekeeping Personnel, Laundry Personnel, Therapy Personnel, and Administrative staff will receive in- service education by the Staff Development Coordinator, RN Supervisor, Unit Coordinators, and/or Director of Nursing on or before 3/19/18 regarding the requirements for compliance with F880 with emphasis on	

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F 880	Continued From page 50 entering a resident's room that was on enteric isolation precautions was to follow the posted sign on the door and perform hand hygiene and don an isolation gown and gloves before entering a resident's room. An interview on 2/15/18 at 9:40 am with the Director of Nursing (DON) revealed that it was her expectation for everyone to follow the posted signage for any type of isolation and perform hand hygiene and don an isolation gown and gloves before room entry. An interview on 2/15/18 at 10:42 am with the Administrator revealed that it was his expectation that everyone entering a room with posted signs regarding any type of isolation follow the instructions on the sign to perform hand hygiene and don an isolation gown and gloves before room entry. An interview on 2/15/18 at 11:44 am with the nurse practitioner (NP) caring for Resident #87 revealed that C-diff was still an active infection for the resident. The NP further stated that it was her expectation that all staff follow the posted signage for isolation rooms and perform hand hygiene and don an isolation gown and gloves prior to room entry. An interview on 2/16/18 at 2:58 pm with Resident #87's physician revealed that it was his expectation that anyone entering a resident's room with posted signs regarding any type of isolation follow the instructions on the sign to perform hand hygiene and don an isolation gown and gloves before entering the room. The physician also stated that when isolation procedures for C-diff were not followed there was	F 880	the use of contact precautions in addition to standard precautions for residents with known or suspected illnesses that are easily transmitted by direct resident contact or contact with items in the residents personal environment. How the corrective actions will be monitored toEnsure the practice will not recur, i.e. what Quality assurance program will be put into place: To ensure ongoing compliance, the Director of Nursing, Staff Development Coordinator, Unit Coordinators and/or RN Supervisor will randomly observe staff interaction with residents on enteric/ contact precautions daily for four (4) weeks, then three (3) times a week four (4) weeks, and then once a week for one (1) month to determine if proper procedures and precautions are adhered to. Findings of these audits will be reported at the monthly QAPI meeting until such time substantial compliance has been achieved and the committee recommends quarterly oversight by the District Director of Clinical Services or designee to maintain compliance when completing clinical system reviews. The Director of Nursing is responsible for implementing the acceptable plan of correction.	

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F 880	Continued From page 51 a risk of spreading C-diff spores (potentially infectious material) throughout the facility.	F 880		