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	345130	A. BUILDING _____ B. WING _____	C 03/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT CONCORD	515 LAKE CONCORD ROAD CONCORD, NC 28025

(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 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff	F 565	Preparation and/ or execution of this plan	4/20/18

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

Electronically Signed | 04/16/2018

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F 565	Continued From page 1 interviews, the facility failed to record and resolve grievances that were reported in Resident Council meetings for 3 of 3 consecutive months. The findings included: Observation of a Resident Council meeting was conducted on 3/21/18 at 2:30 PM and revealed an issue with concerns voiced about the food being cold and not being served in a timely manner and the resolution of the Resident Council grievances. The residents in the meeting reported having expressed concerns about the food including temperature and delivery of the food on the halls. The residents stated they had discussed their concerns about the temperature of the food and the food not being served on time. The residents stated the Activity Director wrote down their concerns but they were never addressed. The Activity Director stated there had been a changeover in the dietary department. The Dietary Manager had come to the meeting in February and wrote down their concerns. He left that position and the facility did not have a permanent Dietary Manager yet. Review of the Resident Council Meeting minutes from 1/3/18, 2/2/18 and 3/1/18 was completed. The following was noted: 1/3/18-a nursing concern was voiced that D hall residents complained that it took 30 minutes at times to get their food tray when meals were served on the hall. 2/2/18-a nursing concern was voiced that residents from the B, C and D halls stated that their trays were cold when the tray was delivered to their rooms. They stated that staff was talking	F 565	of correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/ or executed solely because it is required by the provisions of federal and state law. Corrective action has been accomplished for the alleged deficient practice in regards to food being cold and not being served in a timely manner. All Resident Council concerns have been investigated, responded to residents, by effected department manager and residents agree with actions taken to correct. As evidence by resident council meeting on April 4th the issue of food being cold and not being serve in a timely manner has been resolved and is no longer a concern. Current facility residents have the potential to be affected by the alleged deficient practice by not having resident concerns responded to in a timely with actions taken. Measures put in place to ensure the alleged deficient practice does not reoccur include: Concerns brought to the Activity Director during resident council meetings will be documented on grievance forms and given to the Social Worker for distribution	

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F 565	Continued From page 2 and not delivering timely. It happened on both shifts but mostly on 2nd shift (3:00-11:00 PM). The dietary manager was at that meeting and explained to the residents what the temperatures of the food was supposed to be when taken to the halls. 3/1/18-a nursing concern was voiced that residents from C and D halls stated that their trays are cold when they arrived at their rooms. Residents stated, from the time it was announced trays were on the hall, it took 30 minutes or more for the trays to be delivered to their rooms. On 3/21/18 at 3:20 PM, an interview was conducted with the Activity Director who stated she wrote down the concerns voiced during the Resident Council meetings and wrote the concerns on a Resident Council Concern Follow-up form separating the concerns by department. The Activity Director said she gave the Resident Concern Follow-up forms to the Social Worker who distributed them to each individual department head for their response. Each department head responded to the concerns, gave their responses to the Social Worker. The Social Worker kept a notebook of the responses to the Resident Council concerns and gave the Activity director a copy of the responses to be read at the next Resident Council meeting. A review of the Resident Council Concern Follow-up response sheets revealed the concern about the food that was being served on the halls was taking 30 minutes or more to be delivered to the rooms and not being delivered in a timely fashion was not transcribed to the Resident Council Concern Follow-up forms for January,	F 565	to correct departments. Social work will ensure that all concerns are documented on the concerns form. All concerns will be given to Social Worker upon receipt. The grievances will be reported during the meeting the following months resident council by the activity staff. The social worker will in-service activity staff on the grievance procedure with special attention to those obtained during the Resident Council. All grievances will go through the grievance officer, which is the Social Worker, who will summarize grievances. The Administrator will sign off on each month Resident Council minutes to ensure issues were resolved from the previous month. To ensure deficient practice does not reoccur any observations/ or concerns will be reported Quality Assessment and Assurance Committee by Social Worker for 3 months. QA&A committee will review and revise plan if needed to monitor compliance.	

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F 565	Continued From page 3 February or March 2018 and, therefore, was not addressed by the nursing department head. On 3/23/18 at 11:41 AM, a second interview was conducted with the Activity Director. She stated she completed the Resident Council Concern Follow up form prior to writing the minutes of the meeting. The Activity Director stated the concern regarding the length of time it took nursing staff to deliver the food trays thereby serving cold food was an oversight and it should have been written on the Resident Council Concern Follow up form. She said she did not attach a copy of the minutes when she gave the Social Worker the Resident Council Concern Follow up form. The Activity Director said she was not aware that the concerns regarding meal trays not being delivered in a timely fashion was not transcribed on the Concerns form. On 3/23/18 at 2:56 PM, an interview was conducted with the Administrator. She stated she expected concerns voiced during the Resident Council meeting should be noted on the Resident Council meeting minutes and on the Resident Council Follow-u form. There should be a follow through by the Activity Director to include those concerns on the Resident Council Follow up forms so a resolution to those concerns can be resolved before the next Resident Council meeting.	F 565		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's	F 636		4/20/18

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F 636	Continued From page 4	F 636		

functional capacity.

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

§483.20(b)(2) When required. Subject to the

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F 636	Continued From page 5 timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to complete the Quarterly Minimum Data in the areas of section B, C, D and E for one of twenty-one sampled residents (Resident #103). The fndings included: Resident #103 was admitted to the facility 11/13/17. Cumulative diagnoses included, in part, unspecified psychosis, dementia without behavioral disturbance and major depressive disorder. A Quarterly Minimum Data Set (MDS) assessment dated 2/23/18 was reviewed. The following areas were not completed: section C0100 Should Brief Interview for Mental status (BIMS) be conducted was documented as "not assessed". Sections for Brief Interview for Mental Status (BIMS) C0200, C0300, C0400, C0500, C0700, C0800, C1000 was documented as "not assessed '. Delirium C1310was documented as not assessed/ no information. Mood D0100 was	F 636	F 636: Resident #63: Significant correction of a prior quarterly assessment was completed on 4/12/18 and submitted on 4/12/18 by Regional Clinical Director Reimbursement Coordinator. Current residents have a potential to be affected by the deficient practice. An audit of section B, C. D, E, Q for assessments completed over the past 30 days was completed on 4/12/18 by the Clinical Director Reimbursement Coordinator . Additional incomplete assessments identified by the Clinical Director Reimbursement Coordinator and have significant corrections completed. Measures put into place to ensure the alleged deficient practice does not recur: Current facility staff Minimum Date Set Nurse, Social Worker, Dietary Manager,	

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F 636	Continued From page 6 not assessed, Mood interview was noted as not assessed by resident and staff; section E0100 potential indicators of psychosis and the behavior sections E0200, E0800, E0900.E1000 and E1100 was not assessed. On 3/22/18 at 1:38 PM, an interview was conducted with the Social Worker. She said she completed sections B, C, D, E and Q on the MDS. The Social Worker stated she was the only person who completed those sections. If she was working, her assessment information was completed within the assessment reference date (ARD) time frame. She stated when she completed the sections, she also wrote a social work progress note in the computer. The Social Worker checked the medical record for Resident #103. There was not a social worker note in the system and the Social Worker said she must not have assessed Resident #103. She was not sure why the assessment and social work note had not been done. On 3/22/18 at 1:46 PM, an interview was conducted with the MDS Nurse. She stated she asks everyone to complete their section of the MDS. If that section is coded green, the assessment is locked. The MDS Nurse reviewed the quarterly assessment for Resident #103 and stated she signed the MDS as complete on 3/10/18. All the sections noted by the Social Worker (sections, B, C, D and E were noted as note assessed and signed by the Social Worker 3/9/18. The MDS Nurse indicated she might look at all the sections of the MDS to see if they had been completed and sometimes, she doesn't. She stated her expectation was for all the sections to be completed.	F 636	Therapy Staff, Activity Director that participate in completion of the MDS were provided education on 4/12/18 by Regional Clinical Reimbursement Coordinator with no negative findings, in regards to the requirement of item set completion using the MDS 3.0 V1.15 manual, for all sections and for areas of deficiencies regarding Section B, C, D, E, Q dashes. Newly hired staff members that will be responsible for completing MDS sections will receive education during orientation. Director of Nursing and/or Minimum Data Set Nurse will review section B, C, D, E, Q, weekly x4 weeks, bi-weekly x 1 month for all scheduled assessments section B, C, D, E, Q section prior to submission, to validate the MDS assessment is without dashes. There after 5 assessments will be reviewed monthly x 1 months, prior to submission, to validate accuracy of coding. Administrator and/or Director of Nursing will analyze MDS audits/reviews for patterns/trends and report to Quality Assurance committee meeting monthly for 3 months to evaluate the effectiveness of the plan and will adjust the plan based on outcome/trends identified per committee recommendations.	

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F 636	Continued From page 7 On 3/23/18 at 11:15 AM, an interview was conducted with the Assistant Director of Nursing. She stated she expected the MDS information to be complete and accurate.	F 636		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) in the areas of prognosis for a resident who received hospice services (Resident #63), range of motion and dental status (Resident #12) for 3 of 21 residents reviewed for MDS accuracy. The findings included: 1. Resident #63 was admitted to the facility 10/31/17. Cumulative diagnoses included, in part, Alzheimer's disease, congestive heart failure and edema. Resident #63's payor source on admission was Hospice. A Quarterly MDS dated 2/7/18 indicated Resident #63 was moderately impaired in cognition. Section J1400 prognosis was documented as no for resident having a condition or chronic disease that may result in a life expectancy of less than 6 months. Section O indicated Resident #63 received hospice care during the assessment period. On 3/22/18 at 1:58 PM, an interview was conducted with the MDS Nurse who stated, if	F 641	F 641: Resident #63 and #12: Corrections were completed and submitted 03/26/2018 and 04/12/2018 for the inaccurate coding: Resident #63; Minimum Data Set Nurse modified the quarterly 02/07/2018, to accurately reflect a "yes" response to J1400 Prognosis. Resident #12; Minimum Date Set Nurse modified the 12/22/2017 annual assessment section of G0400 Functional limitations ROM to reflect functional limitations of the residents left upper extremity, In addition Section L Oral and Dental status was modified to reflect missing/decayed teeth present. Current residents have a potential to be affected by the alleged deficient practice. An audit of MDS assessments for the past 30 days was completed on 4/12/18/ for Section G0400, Section L without further inaccuracies noted. Measures put into place to ensure the alleged deficient practice does not recur: Current facility staff that participate in	4/20/18

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F 641	Continued From page 8 resident was on hospice, the area for prognosis should be yes for less than 6 months. On 3/23/18 at 11:10 AM, an interview was conducted with the Assistant Director of Nursing. She stated she expected the MDS to be accurate. 2. a. Resident #12 was admitted to the facility on 12/29/2016 with diagnoses to include cerebral vascular accident, cognitive communication deficit and high blood pressure. The occupational therapy progress note dated 12/11/2017 was reviewed and the Occupational Therapist (OT) noted Resident #12 had limited ROM of the left arm, including the left shoulder, elbow and wrist. The annual MDS assessment dated 12/22/2017 assessed Resident #12 to be moderately cognitively impaired and he required extensive one-person assistance with bed mobility, toileting, hygiene and two-person assistance with transfers. He was totally dependent for bathing. Section G 0400A "functional limitation in range of motion" was answered 0 "no impairment" for upper and lower extremity range of motion. Resident #12 was observed on 3/20/2018 at 10:57 AM. The resident was noted to have limited ROM of his left arm, including his shoulder, elbow and wrist. An interview was conducted with OT #1 on 3/23/2018 at 8:21 AM. She reported she had provided therapy services to Resident #12 and he was discharged from services on 12/22/2017. OT #1 explained he had continued limited ROM of	F 641	completion of the Minimum Data Set Nurse was provided education on 4/12/18 by Clinical Director Reimbursement Coordinator regarding the importance of accuracy of assessments, using the MDS 3.0 V1.15 manual, MDS accuracy of all sections and for areas of alleged deficiencies and section requirements: Newly hired staff members that will be responsible for completing MDS sections will receive education during orientation by the Director of Nursing. Director of Nursing and/or Minimum Data Set Nurse will review weekly x4 weeks, bi-weekly x 1 month for all scheduled assessments, to validate the MDS assessment is coded accurately. There after 5 assessments will be reviewed monthly x 1 months, prior to submission, to validate accuracy of coding. Administrator and/or Director of Nursing will analyze audits/reviews for patterns/trends and report to Quality Assurance Committee meeting monthly for 3 months to evaluate the effectiveness of the plan and will adjust the plan based on outcome/trends identified per committee recommendations.	

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F 641	Continued From page 9	F 641		

the left shoulder, elbow and wrist. OT #1 further reported at the completion of occupational therapy, an order was taken to the MDS coordinator which noted continued limitations of the resident and orders for restorative nursing assistants.

The MDS Coordinator was interviewed on 3/23/2018 at 8:33 AM. She reported she had been in the coordinator position for about one year. She further reported that she had not completed the annual MDS assessment for Resident #12 dated 12/22/2017, but the part-time MDS nurse had completed the assessment. The MDS Coordinator was not aware Resident #12 had limited ROM of his left arm. The MDS Coordinator concluded by stating she expected the MDS to be coded correctly.

An interview was conducted with the Administrator on 3/23/2018 at 4:38 PM. She reported it was her expectation the MDS assessments were coded accurately.

2. b. Resident #12 was admitted to the facility on 12/29/2016 with diagnoses to include cerebral vascular accident, cognitive communication deficit and high blood pressure.

The annual Minimum Data Set (MDS) assessment dated 12/22/2017 assessed him to be moderately cognitively impaired. Section L0200 "Dental" was coded "Z. None of the above were present" regarding broken teeth, or likely cavities.

Resident #12 was observed on 3/20/2018 at 3/20/2018 at 10:57 AM. The resident was noted to have very poor dentation with missing teeth

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F 641	Continued From page 10 and natural teeth that appeared to have decay. The Speech Therapist was interviewed on 3/22/2018 at 4:17 PM. She reported Resident #12 was seen for speech therapy. She further reported the resident had broken teeth and poor dentation. The MDS Coordinator was interviewed on 3/23/2018 at 8:33 AM. She reported she had been in the coordinator position for about one year. She further reported that she had not completed the annual MDS assessment dated 12/22/2017 for Resident #12, but the part-time MDS nurse had completed the assessment. The MDS Coordinator was not aware the resident was missing teeth, but reported if he had missing teeth or decay, it should have been coded on the assessment. The MDS Coordinator concluded by stating she expected the MDS to be coded correctly. An interview was conducted with the Administrator on 3/23/2018 at 4:38 PM. She reported it was her expectation the MDS assessments were coded accurately.	F 641		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews, the facility failed to monitor	F 658	Deficient practice allegedly occurred when resident #63 reported her air	4/20/18

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F 658	Continued From page 11 and document the air mattress pressure for comfort for one of one residents reviewed for hospice (Resident #63). The findings included: Resident #63 was admitted to the facility 10/31/17. Cumulative diagnoses included, in part, Alzheimer's disease, congestive heart failure and edema. A Quarterly MDS dated 2/7/18 indicated Resident #63 was moderately impaired in cognition. She required extensive assistance of two people for bed mobility. On 3/20/18 at 4:16 PM, Resident #63 was observed lying in bed. She was lying on an air mattress. The pressure in the mattress was at firm (total pressure). Resident #63 stated the mattress was uncomfortable and too hard. On 3/21/18 at 5:45 PM, an interview was conducted with the Administrator who stated the air mattress was provided by hospice services. She was unsure of who made sure mattress pressure was comfortable for Resident #63. On 3/22/18 at 2:10 PM, urinary catheter care was observed. NA#2 and NA#3 stated they had the nurse put the mattress on firm (total pressure) while they provided care for the safety of the resident and they would have the nurse redo the firmness of the mattress on completion of care. Both stated they did not do anything to change the firmness of the mattress. Resident #63 stated the comfort of the mattress was better today. On 3/23/18 at 8:30 AM, Resident #63 was in bed with the head of her bed raised approximately 45 degrees. The air mattress pressure was on "4".	F 658	mattress uncomfortable with no order for air mattress in resident□s medical record. A Physician□'s order for an air mattress for resident #63 obtained on 3/23/2018. Residents with air mattresses have the potential to be affected. A visual audit of all residents□ rooms for placement of air mattresses was completed on 4/11/2018 by the Unit Managers. Visual observation audit revealed setting for air mattresses were appropriate for the resident. Air mattress orders were clarified by the Unit Manager on 4/11/2018 and written to include the number setting for each resident with an air mattress in place. Air mattress function and settings will be monitored and documented on the MAR every shift by licensed nurse. To ensure alleged deficient practice does not reoccur Unit Managers, licensed nurse or Director of Nursing will audit resident rooms with an air mattress in place to ensure air mattress settings are according to physician'□s order□s daily for 2 weeks, and then weekly for 4 weeks then monthly. Unit manager or other assigned licensed nurse will audit MARS for accurate and complete documentation of air mattress function and setting levels daily for 2 weeks, weekly for 4 weeks, and then monthly. Director of Nursing will analyze and review audit and report findings in QA&A every 3	

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F 658	Continued From page 12 On 3/23/18 at 9:00 AM, an interview was conducted with Nurse #4 who stated she thought the facility treatment nurse monitored the air mattress for firmness. On 3/23/18 at 10:13 AM, an interview was conducted with Nurse #5. She stated she thought the monitoring of the air mattress pressure was on the Treatment Administration Record (TAR). Nurse #5 reviewed Resident #63 ' s TAR and said, since there was no documentation about monitoring of the air mattress pressure on the TAR, hospice must monitor the air mattress pressure. On 3/23/18 at 11:10 AM, an observation of Resident #63's air mattress was conducted with the Assistant Director of Nursing (ADON). The air mattress pressure was on #4 and she stated the air pressure is based on resident's weight and the mattress should be on 4-5. Resident #63 was lying bed and stated the mattress was very uncomfortable and, every time she tried to sit up straight or move to the left, the air mattress made her lean to the right side. Resident was alert at the time of the observation. On 3/23/18 at 11:15 AM, an interview was conducted with the ADON. She stated hospice brings the air mattress to the facility but it was the responsibility of the nursing staff to monitor and document that the air mattress was functioning properly on the Medication Administration Record (MAR). She reviewed the medical record for Resident #63 and stated there was no physician's order for the air mattress. She stated a physician order should have been generated in the computer so the air mattress pressure would be	F 658	months. Findings will be reviewed by QA&A committee with recommendations to maintain compliance.	

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F 658	Continued From page 13 monitored by nursing staff on the MAR. The ADON stated the order should have been written to check and document if the air mattress was functioning properly every 4 hours.	F 658		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, resident and staff interviews, the facility failed to apply ordered splints to three of five residents reviewed (Residents #11. 12 and 69). Findings included: 1. Record review of Resident #11's medical record revealed diagnoses of Epilepsy, Cerebral Palsy, Dysphagia, Quadriplegic, Asthma, and Contractures. Review of Physician Order dated 5/4/14 revealed an order for Bilateral Resting Hand Splints and Passive Range of Motion 4 to 6 hours daily for 6 days a week. Review of Minimum Data Set Annual (MDS) Assessment dated 3/21/17 revealed Resident #11 required total assistance of two staff members for	F 684	F684: Resident #11, #12 and #69 splinting requirements were placed on the Treatment Administration Record to record splints are applied in the Am and removed in PM. Current residents with orders for splints have a potential to be affected by the deficient practice. An audit was conducted by the Regional Clinical Reimbursement Coordinator to identify residents with splints was completed this was completed on 4/12/2018 with corrections made as needed. Measures put into place to ensure the deficient practice does not recur: Current Register Nurses /License Nurses , Certified Nursing Assistants and rehab staff that provide treatment to facility	4/20/18

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F 684	Continued From page 14 turning in bed and transfers in and out of bed; and she required total assistance of one staff member for eating and toileting. She did not receive any Restorative Nursing according to the MDS documentation. She was also severely impaired for daily decision making and had functional limitations of range of motion in her bilateral upper and lower extremities. Review of Minimum Data Set Quarterly (MDS) Assessment dated 12/22/17 revealed Resident #11 required total assistance of two staff members for toileting; total assistance of one staff member for eating; extensive assistance of two staff members for turning in the bed; and extensive assistance of one staff member for transfer from the bed. She was also severely impaired for daily decision making. Review of the Restorative Nursing Documentation for February 2018 revealed Resident #11 did not have bilateral hand splints applied 20 out of the 25 days they were ordered. Review of the Restorative Nursing Documentation for March 2018 revealed Resident #11 did not have bilateral hand splints applied 11 days out of the 19 days they were ordered. Observation of Resident #11 on 3/20/18 at 12:27 pm revealed contractures to her hands and no splints were observed. Review of Resident #11's Care Plan dated 3/21/18 revealed a care plan for limited mobility and further risk of contractures due to Cerebral Palsy and Paralysis with Spastic Contractures. The intervention of use of splints to prevent further contractures was listed.	F 684	residents will be provided education by The Director of Nursing to ensure the placement and removed of splints for AM/PM is monitored. In addition, any newly identified resident(s) requiring splint(s)s will be added to the Treatment Administration Record upon receipt of notice to the Unit Manager from Therapy. Newly hired RN/LPN that provided treatments, will receive education during orientation. Director of Nursing and/or designee will review weekly x4 weeks, bi-weekly x 1 month for all residents with splints for placement on the TAR (Treatment Administration Record), with random visual verification that splints are in place. There after 5 assessments will be reviewed monthly x 1 months to validate placement on the TAR, application and removal of splints AM/PM. Director of Nursing and/or Unit Managers will analyze audits/reviews for patterns/trends and report to Quality Assurance committee meeting monthly for 3 months to evaluate the effectiveness of the plan and will adjust the plan based on outcome/trends identified per committee recommendations.	

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During observation of care on 3/22/18 at 10:00 am Nurse Aide (NA) #4 stated Resident #11 had bilateral hand/wrist splints that were applied by restorative care daily.

Observation of Resident #11 on 3/23/18 at 9:34 am revealed she had no splints on.

Observation of Resident #11 on 3/23/18 at 4:55 pm revealed she had no splints on.

During an Interview with Nurse #4 on 3/23/18 at 9:32 am she stated the Nurse Aides would not put splints on residents, the Restorative Aides applied all splints.

Interview on 3/23/18 at 9:40 am with Restorative Nurse's Aide #3 revealed she did not have time to apply Resident #11's splints on 3/22/18. She stated she was pulled to do other tasks and was not able to apply the splints. She stated Resident #11 missed having her splints three days out of the six days a week they are ordered because she is pulled to a regular assignment or given other tasks to do.

Interview with Occupational Therapist #1 on 3/23/18 at 10:40 am revealed Resident #11 had been treated 5/15/15 to 5/29/15 for bilateral hand/wrist splints. She stated the splints were brought with the resident on admission and were used to prevent any further contracture to her hands and wrists. Occupational Therapist #1 also stated the bilateral hand/wrist splints kept Resident #11's wrists and fingers from becoming "locked" in a closed position.

Interview on 3/23/18 at 2:06 pm with the Director

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of Nursing revealed her expectation was the Restorative Aides would apply and monitor splints as they are ordered. She also stated if the Restorative Aides were pulled to an assignment then the Nurse Aide assigned to the resident should make sure the splints are applied as ordered.

Interview with the Administrator on 3/23/18 at 3:40 pm revealed her expectation was that all splints would be applied as ordered. She stated if the Restorative Aides were not available to apply them then the Nurse Aide and Nurse assigned to the resident should apply them.

2. Resident #12 was admitted to the facility on 12/29/2016 with diagnoses to include cerebral vascular accident, cognitive communication deficit and high blood pressure.

The annual Minimum Data Set (MDS) assessment dated 12/22/2017 assessed Resident #12 to be moderately cognitively impaired and he required extensive one-person assistance with bed mobility, toileting, hygiene and two-person assistance with transfers. He was totally dependent for bathing.

The occupational therapy (OT) process note dated 12/11/2017 was reviewed and the OT noted Resident #12 had limited range of motion (ROM) of the left arm, including the left shoulder, elbow and wrist. The OT progress noted documented Resident #12 had required a splint for his left arm to applied daily with the splinting time goal 6-8 hours to "achieve proper positioning for maximal

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independence during functional activities, including eating, activities of daily living tasks, leisure pursuits and functional mobility."

A care plan was in place for Resident #12 to receive restorative nursing for passive range of motion (PROM) of the left upper arm and hand dated 12/27/2017. The care plan included interventions to apply the left hand splint for 6 to 8 hours per day after PROM was performed on the left upper arm.

A care plan dated 1/12/2017 was in place that addressed Resident #12 ' s resistance to care with interventions to include monitoring and documenting behaviors, approach after agitation, guide from source of distress and provide time to allow resident to express his feelings.

Occupational therapy notes were reviewed. There were documentation of Resident #12;s refusal to participate in therapy on 11/21/2017, 11/22/2017, 12/13/2017, 12/20/2017 and 12/21/2017.

Nursing rehab/restorative notes from February and March 2018 were reviewed and under the interventions "perform PROM exercises to left upper arm six times per week for 15 minutes" one instance in February 2018 and one instance in March 2018 where the PROM exercises were documented as done. The other dates were documented as "97", not applicable. There were no instances of refusals documented.

Under the interventions "apply left hand splint 6-8 hours per day" one instance in February 2018 and one instance in March 2018 were documented that the splint was applied for 15 minutes. The other dates were documented as

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"97", not applicable. There were no instances of refusals documented.
Resident #12 was observed on 3/20/2018 at 10:57 AM. The resident was noted to have limited ROM of his left arm, including his shoulder, elbow and wrist. An upper extremity splint was noted on the nightstand in the resident ' s room.
The resident was interviewed on 3/20/2018 at 10:57 AM. Resident #12 reported staff applied the splint to his left arm "sometimes".
Nursing assistant (NA) #1 was interviewed on 3/22/2018 at 3:56 PM. She reported she was a restorative NA. She reported she was familiar with Resident #12. She further explained that she was not applying splints to Resident #12 and the nursing staff was applying the splints.
An interview was conducted with NA #2 and NA #3 on 3/23/2018 at 9:23 AM. Both NA #2 and #3 reported they had been restorative NA at the facility for many years. Both reported they received special training by the rehabilitation services for PROM and splint application. They reported orders for restorative were in the kiosk for documentation after restorative interventions had been performed. NA #3 reported that Resident #12 was resistant to care and could become combative, but the restorative NA would approach him several times to perform PROM and apply the splint. NA #2 reported the documentation would capture only one attempt to perform PROM or splint application. NA #3 reported that restorative aides were frequently pulled from restorative care to a hall assignment and that did not allow the restorative aides to perform all their duties. NA #3 concluded by reporting that each NA should perform PROM with bathing and morning care, but only the restorative aides should apply the splints.
Nurse #3 was interviewed on 3/22/2018 at 4:05

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PM. She reported that restorative NA should be applying the splints to residents.
An interview was conducted with OT #1 on 3/23/2018 at 8:21 AM. She reported she had provided therapy services to Resident #12 and he was discharged from services on 12/22/2017. She reported he had continued limited ROM of the left shoulder, elbow and wrist. OT #1 reported that splinting for residents was not written as an order, but a form was filled out and given to the MDS coordinator and those instructions were given to the restorative aides. The OT went on to explain the resident was non-compliant at times and would refuse care. The OT concluded that she had taken the restorative orders to the MDS coordinator and the MDS coordinator would develop the care plan and the interventions for the resident.
The MDS coordinator was interviewed on 3/23/2018 at 8:33 AM. She reported she initiated the care plan for restorative nursing services for the resident. She explained that she would update the care plans and instruct the restorative aides on the interventions needed for the residents under the restorative program. She reported she felt the PROM and the splints were not applied because the resident refused, or because the restorative aides were pulled to work a floor assignment.
An interview was conducted with the Administrator on 3/23/2018 at 4:38 PM. She reported she expected the orders to be followed and for disciplines to communicate with each other regarding the care of the residents.
3. Resident #69 was admitted to the facility on 5/13/2016 and readmitted on 8/23/2017 with diagnoses to include Multiple Sclerosis, high blood pressure and diabetes.

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The most recent quarterly MDS assessment dated 2/12/2018 assessed the resident to be cognitively intact and she required extensive two-person assistance with bed mobility, transfers, toileting, hygiene, extensive one-person assistance with dressing and total assistance with bathing. The resident was scored as having limited range of motion (ROM) on both sides of her upper and lower body.

Care plans for Resident #69 were reviewed and a restorative care plan was in place and last updated 6/23/2017. The goal stated she would continue to function at her current level while participating in restorative nursing program. There were no interventions for the application of splints noted in the care plan. The interventions included notifying the physician of refusals for care.

Physician orders for the resident as well as the Nursing rehab/restorative notes from February and March 2018 were reviewed and no orders were found regarding PROM or splint application. There was no documentation regarding PROM or application of splints.

A review of the nursing/rehabilitation orders revealed that an order for PROM of the left arm and application of splints for 6-8 hours had been initiated on 2/28/2018 and discontinued on 3/1/2018.

Resident #69 was observed on 3/20/2018 at 10:35 AM. It was noted she had limited ROM of her left arm am.
An interview was conducted with Resident #69 on 3/20/2018 at 10:35 AM. She reported that a splint

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was applied by the occupational therapist.

An interview was conducted with NA #1. She reported she was a restorative NA. She reported that Resident #69 had a left arm splint that was applied by therapy.

An interview was conducted with NA #2 and NA #3 on 3/23/2018 at 9:23 AM. Both reported they received special training by the rehabilitation services for PROM and splint application. They reported orders for restorative services were in the kiosk for documentation after restorative interventions had been performed. NA #3 reported that Resident #69 was seen by occupational therapy and the restorative NA would not apply splints when a resident was on the therapy caseload. NA #3 reported that restorative aides were frequently pulled from restorative care to a hall assignment and that did not allow the restorative aides to perform all their duties. NA #3 concluded by reporting that each NA should perform PROM with bathing and morning care.

Nurse #3 was interviewed on 3/22/2018 at 4:05 PM. She reported the restorative NAs were applying the left arm splint to Resident #69.

An interview was conducted with OT #1 on 3/23/2018 at 8:21 AM. She reported she had provided therapy services to Resident #69 for shoulder pain. She further reported the splint to the resident ' s left arm would be the responsibility of the restorative aides because she was not providing therapy to the left arm related to the limited ROM.

The MDS coordinator was interviewed on

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F 684	Continued From page 22 3/23/2018 at 3:50 PM. She reported Resident #69 was not on the list of residents receiving restorative nursing care. The MDS coordinator concluded by reporting she was not certain who was responsible for the application of splints or performance of PROM for Resident #69. An interview was conducted with the Administrator on 3/23/2018 at 4:38 PM. She reported she expected the orders to be followed and for disciplines to communicate with each other regarding the care of the residents.	F 684		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by:	F 693		4/20/18

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F 693	Continued From page 23 Based on record review, observation and staff interviews the facility failed to ensure the resident was provided safe enteral feeding for 1 of 1 residents reviewed, Resident #11. Resident #11 received enteral feedings while lying flat on her back. Findings included: A review of Resident #11's medical record revealed she was admitted on 5/4/14 with diagnoses of Epilepsy, Cerebral Palsy, Dysphagia, Asthma, and Quadriplegia. A review of Resident #11's physician's orders dated 5/5/14 revealed an order for the head of the bed to be elevated 30 degrees to prevent aspiration. A review of Resident #11's physician's orders dated 1/29/18 revealed an order for Isosource Feeding at 30 cc/hour via tube with water flushes of 120 ml every 4 hours via dual flow pump. A review of the In-Service Education for 2017 and 2018 revealed no in-services related to care of residents with enteral feedings for the Nurse Aide staff. On 3/22/18 at 10:00 am during an observation of catheter care Nurse Aide #4 laid Resident #11 flat in the bed with the tube feeding infusing. Nurse Aide #4 stated she had not received any in-services or education by the facility on how to manage a feeding tube during care. She stated she wasn't aware she should ask the nurse to stop the feeding. On 3/23/18 at 2:06 pm an interview with the Director of Nursing revealed her expectation was	F 693	F 693 Deficient practice allegedly occurred when a nursing assistant laid resident #11 flat to provide peri care, while resident was receiving continuous enteral feeding via G- tube. Residents with enteral tube feedings have potential to be affected. The nursing assistant assigned to Resident #11 was in serviced 3/22/2018 by Unit Manager regarding the procedure when providing care to a resident receiving enteral tube feedings. Nursing assistants will be trained regarding the procedure to provide care for residents receiving eternal feedings including but not limited to requesting assistance for the licensed nursing staff to turn off or turn on feeding prior to rendering care or completing care. Residents who receive enteral feedings have the potential to be affected. Current residents with enteral feedings were identified. Unit Manager or Supervisor will observe ADL care of resident□s receiving enteral feeding 3 times a week for 4 weeks then weekly for 1 month. Director of Nursing will review and analyze observation results and report findings of observations to QA&A committee for 3 months. QA&A committee will review and revise plan if needed to monitor compliance.	

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F 693	Continued From page 24 residents with enteral feeding would require the Nurse Aide to ask the Nurse to stop the feeding before providing care and ask the Nurse to restart the feeding after care is completed. The Director of Nursing stated Resident #11 should never have been laid flat while the feeding was administered. On 3/23/18 at 3:40 pm and interview with the Administrator revealed her expectation was the Nurse Aides should call a Nurse to the room before providing care to stop an enteral feeding before lying the resident flat and have the Nurse restart the enteral feeding after the care is completed.	F 693		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and	F 725		4/20/18

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F 725	Continued From page 25 (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, the facility failed to provide nursing staff of sufficient quantity and quality to provide restorative services for three of five residents reviewed for positioning and mobility (Resident #12, #11 and #69). The findings included: This citation is cross-referenced to F684. Based on record reviews, observations, resident and staff interviews, the facility failed to apply ordered splints to three of five residents reviewed (Residents #11. 12 and 69). On 3/23/18 at 9:23 AM, an interview was conducted with NA#2. She stated she had been a restorative aide for 7-8 years. NA#2 stated restorative nursing staff were getting pulled for a regular assignment on the floor. She stated they do the daily weight, then ambulation and splinting. She said they cover the dining room for two meals, assist those who need help with eating and document intake. NA #2 stated they get pulled to do a regular assignment a lot. When they were not doing the restorative assignments, they did not have the time to apply splints and/or get daily weights. She said sometimes it was one of the restorative aides and sometimes it was all three of them. On 3/23/18 at 9:40 AM, an interview was	F 725	Resident #11. #12 and #69 splinting requirements were placed on the Treatment Administration Record to verify splints are applied in the AM and removed in the PM. Current open nursing assistant positions are posted on Career Builder, Indeed.com as well as the company's website. The facility is interviewing and hiring qualified ancillary staff. The facility will continue to do so until open positions are filled. . Current residents with orders for splints have a potential to be affected by the deficient practice. An audit to identify residents with splints was completed by the Regional Clinical Reimbursement Coordinator on 4/12/2018 for identification of residents with splinting needs, splint orders for splint application and removal, and documentation on Medication Administration Record. Measures put into place to ensure the deficient practice does not recur:Current RN/LPN staff that provide treatment to facility residents will be provided education by the Director of Nursing, Unit Manager, or Supervisor beginning on	

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F 725	Continued From page 26 conducted with NA #3. She stated she had been a restorative aide for 20 years. NA#3 stated Resident #11 did not get her splints put on 3/22/18. NA#3 said the restorative aides were doing weights and transfers and NA #2 had to do an assignment at the end of the day so they just didn ' t have time to do them. NA#3 stated Resident #11 probably missed having her splints on 3 days a week because the restorative aides were pulled to the floor or doing weights. She said the regular nursing assistants know when restorative aides are on an assignment because of the daily assignment sheets but they don ' t always apply splints to their residents. On 3/23/18 at 2:06 PM, an interview was conducted with the Assistant Director of Nursing. She revealed her expectation was that the restorative aide would apply the splints and monitor the. She also stated if the restorative aides were pulled to an assignment, the nursing assistant on the hall should make sure the resident have their splints applied as orders. On 3/23/18 at 4:05 PM, another interview was conducted with the Assistant director of Nursing who stated they had several nursing assistants quit and the facility was in the process of replacing them, interviewing and hiring both licensed and unlicensed. She said the facility did not use contract agencies at all and the facility continued to try to get the nursing staff up to par level.	F 725	4/17/2018, to ensure the placement and removed of splints for AM/PM is monitored. In addition, any newly identified resident(s) requiring splint(s)s will be added to the Treatment Administration Record upon receipt of notice to the Unit Manager from Therapy. Newly hired RN/LPN that provided treatments, will receive education during orientation. Director of Nursing, Unit Manager, Supervisor or assigned Licensed Nurse will review weekly x4 weeks, bi-weekly x 1 month for all residents with splints for placement on the TAR (Treatment Administration Record), with random visual verification that splints are in place. The Director of Nursing will monitor staffing needs in conjunction with the Human Resource Manager to identify hiring challenges and advertising needs. Director of Nursing and/or Unit Managers will analyze audits/reviews for patterns/trends and report to Quality Assurance committee meeting monthly for 3 months to evaluate the effectiveness of the plan and will adjust the plan based on outcome/trends identified per committee recommendations.	
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	F 755		4/20/18

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F 755	Continued From page 27 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. §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 record review and staff interviews, the facility failed to administer medications as ordered by the physician for one of seven residents reviewed for unnecessary medications (Resident #18). The findings included: Resident #18 was admitted to the facility 3/14/17. Cumulative diagnoses included Crohn's disease,	F 755	Resident # 18's physician was notified of the medication omission and a hard script was obtained from the nurse practitioner on 3/19/2018 and forwarded to the pharmacy. Resident #18 is his/ her own responsible party and was aware of the medication being unavailable. The resident was assessed by the physician	

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F 755	Continued From page 28 diabetes, generalized anxiety, insomnia, peripheral vascular disease, seizures, bipolar disease and major depressive disorder. A Quarterly Minimum Data Set dated 1/5/18 indicated Resident #18 was cognitively intact. Medications administered during the assessment period included 7 days of antipsychotic, antianxiety, antidepressant and diuretic medication and 1 day of opiod medication. A review of the physician orders for Resident #18 revealed an order dated 2/20/18 for clonazepam (anti-anxiety medication) 0.5 milligrams-- give one tablet every bedtime for seizures. A review of the Medication Administration Record (MAR) for March 2018 revealed clonazepam was not administered on 3/16/18, 3/18/18,3/19/18 and 3/20/18. A nursing note dated 3/16/18 at 10:22 PM by Nurse #2 stated medication (clonazepam 0.5 milligrams) was on order. A nursing note dated 3/17/18 at 9:05 PM by Nurse #6 stated clonazepam tablet 0.5 milligrams. Give 1 tablet by mouth at bedtime for seizures. Medication was on order from pharmacy. A nursing note dated 3/18/18 at 9:16 PM by Nurse #6 stated clonazepam 0.5 milligrams. Give one tablet at bedtime for seizures on order from pharmacy. A nursing note dated 3/19/18 at 10:58 PM by Nurse #2 stated (clonazepam 0.5 milligrams) medication not available.	F 755	on 3/22/2018 with out adverse effects noted. Current facility residents who receive narcotic medications have the potential to be affected by the alleged deficient practice. An audit of the current supply of narcotics was conducted on March 22, 2018 by the Unit Managers with no negative findings. Mandatory in-service for licensed nurses will be provided by the Director of Nursing, Unit Managers, Supervisors or other assigned licensed nurse beginning 3/22/2018 and will continue until all current licensed staff have been trained and will be included during orientation for newly hired nurses related to the process to obtain narcotic medication, specifically, and other medication as necessary, after business hours and procedure if medication is not readily available including notification of nursing administration and physician or physician extender. The DON, Unit Managers, Supervisors or other designated licensed nurse will audit the narcotic storage area on each medication cart for at least 2 times weekly x 4 weeks, then at least 1 times weekly ongoing to ensure narcotic medication is available for administration. The Director of Nursing, Unit Managers, or Supervisors will review data obtained during observations/ audits and report findings to the quality assessment and assurance committee with recommendations to maintain compliance.	

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F 755	Continued From page 29 A nursing note dated 3/20/18 by Nurse #2 stated (clonazepam 0.5 milligrams) medication on order. On 3/22/18 at 3:54 PM, an interview was conducted with Nurse #6. She stated nursing staff directly re-ordered medications by checking the box on the computer or by pulling the medication label and faxing the order to the pharmacy. Nurse #6 said the medication was usually delivered to the facility the next day. She stated Resident #18 was out of clonazepam and someone had not pulled the label to reorder the medication. On 3/22/18 at 3:54 PM, an observation of the medication card for clonazepam 0.5 milligrams for Resident #18 revealed an empty card labeled clonazepam .5 milligrams. Take one tab by mouth at bedtime for seizure. The control sheet showed the last pill was removed from the medication card on 3/15/18 at 9:00 PM. A second medication card for clonazepam 0.5 milligrams. revealed the medication was received at the facility on 3/20/18 and one pill had been removed and documented as given 3/21/18 at 1:10 AM. On 3/22/18 at 4:08 PM, an interview was conducted with the Assistant Director of Nursing. She said medication reorders could be faxed to the pharmacy or reorder from the pharmacy direct on the computer from the physician order. She stated there was an emergency drug box on the A hall medication cart and she thought the clonazepam 0.5 milligrams was in the emergency drug box on that cart. In the event the medication was not in the emergency drug box, nursing staff should have notified the physician via phone on 3/16/18 that the medication wasn't available. The	F 755	The Director of Nursing will be responsible for the implementation for the acceptable plan of correction for completion and accuracy of residents MAR□s.	

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F 755	Continued From page 30	F 755		

Assistant Director of Nursing said controlled medications required a hard script signed by the nurse practitioner or physician and should be reordered 5 days before the medication card was empty. She stated a nurse practitioner was in the facility 5 days a week. The Assistant Director of Nursing checked the emergency drug box and stated clonazepam was not in the emergency kit. She said her expectation was for nursing staff to order the control medication and to call the physician if it was not available for further orders.

On 3/22/18 at 4:28 PM, a telephone interview was conducted with Resident #18 ' s physician. He stated the medication was for insomnia. There was a protocol that was followed for the reordering of medications and the nursing staff should follow the protocol. If a medication was out, the nursing staff should call the on-call physician if the medication was unavailable and physician orders should be followed as written.

On 3/22/18 at 4:30 PM, another interview was conducted with the Assistant Director of Nursing. The hard script for the clonazepam 0.5 milligrams for Resident #18 was printed at the facility for the nurse practitioner to sign on 3/17/18. The nurse practitioner came to the facility and signed the hard script on 3/19/18 and the medication arrived at the facility on 3/20/18 at 12:49 AM.

On 3/22/18 at 4:39 PM, a telephone interview was conducted with the pharmacy customer service liaison. She stated if the medication was a controlled drug, a hard script was required. The facility had to fax the refill request and hard script before the medication could be filled.

On 3/22/18 at 4:53 PM, a Nurse #2 who stated

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F 755	Continued From page 31 she was a new nurse at the facility and had been there about a month. She stated when the clonazepam was not available, nursing staff were supposed to go to the emergency drug box on A hall cart. If the medication was not in the cart, nursing had to print out a hard script, have the nurse practitioner or physician to sign it and fax it to the pharmacy. Nurse #2 said she told another nurse on 3/16/18 that the medication was out and the other nurse told her she would handle printing out the hard script.	F 755		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to maintain a medication error rate of less than 5% as evidenced by a medication error rate of 16% (4 errors out of 25 opportunities) (Resident #95 and Resident #3). Findings included: 1. Resident #95 ' s physician orders were reviewed and he was prescribed ascorbic acid (Vitamin C) 500 milligrams (mg) 1 tablet daily. The resident was not prescribed calcium carbonate antacid tablet. A medication administration was observed on 3/21/2018 at 9:14 AM for Resident #95. Nurse #1	F 759	F759 Deficient practice allegedly occurred when licensed nurse #1 administered calcium carbonate instead of ascorbic acid to resident #95 and licensed nurse #2 administered polyethylene glycol instead of psyllium husk powder to resident #3. Licensed nurses were in serviced on proper identification of medications. MD was notified of incorrect medications being given 3-21-18 for resident #95 and 3-22-18 for Resident #3. Residents were assessed and monitored for adverse effects from receiving incorrect medications. With none noted. The Physician□'s order for ascorbic acid was clarified to include the wording	4/20/18

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F 759	Continued From page 32 missed the administration of ascorbic acid and administered calcium carbonate antacid 500 mg tablet. Nurse #1 was interviewed on 3/21/2018 at 10:21 AM. She reported she did not know that ascorbic acid was Vitamin C or calcium carbonate was a different medication and thought that the resident was ordered the antacid. The Acting Director of Nursing (ADON) was interviewed on 3/23/2018 at 3:42 PM. She reported it was her expectation that if a nurse was not familiar with a medication she would look up the medication prior to administration and the correct medications would be administered. 2. Resident #3 physician orders were reviewed and she was prescribed polyethylene glycol (Miralax) 17 grams (GM) daily at 8:00 AM and psyllium husk powder 1 tablespoon by mouth daily at 5:00 PM. A medication administration was observed on 3/21/2018 at 4:37 PM for Resident #3. Nurse #2 administered polyethylene glycol 17 GM and did not administer the psyllium husk powder 1 tablespoon. Nurse #2 was interviewed on 3/21/2018 at 5:25 PM. The nurse was not certain why she administered the polyethylene glycol and omitted the psyllium husk powder. The ADON was interviewed on 3/23/2018 at 3:42 PM. She reported it was her expectation that the correct medications would be administered at the correct time.	F 759	Vitamin C. To ensure deficient practice does not reoccur. Facility residents who receive medication have the potential to be affected. Director of Nursing, Unit Manager, Supervisor other appointed licensed nurse will observe medication pass 3 times a week for 4 weeks, then weekly for 4 weeks, then monthly for 3 months. Pharmacy staff (RN/ Pharmacist)will observe medication pass monthly for 3 months. New orders will be reviewed by Director of Nursing, Unit Managers or Supervisor to clarity to ensure orders will be understood by the nurse administering the medications. The DON or Unit Manager will review results of med pass observations, analyzing for trends then and reporting findings in Quality Assessment and assurance Committee. QA&A committee will review and revise plan if needed to monitor compliance.	

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F 761	Continued From page 33	F 761		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to dispose of an expired Magic Mouthwash with Viscous Lidocaine 2% solution prescribed for Resident 24 and stored in 1 of 2 of the facility's Medication Storage Rooms. Resident #24 received 57 doses of the expired magic mouthwash.	F 761	F 761: Corrective action has been accomplished for the alleged deficient practice in regards to failure to remove expired Magic Mouth Wash with Viscous Lidocaine 2%. Expired medication/ mouth wash was immediately removed and discarded. A refill was obtained and the bottle label indicates expiration date.	4/20/18

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F 761	Continued From page 34 Findings Included: An observation of the locked refrigerator in the C/D Hall medication room on 3/23/18 at 10:25 am revealed an open bottle of Dukes Magic Mouthwash with Viscous Lidocaine 2% for Resident #24 and noted to have expired on 3/8/18. Review of the Medication Administration Record for March 2018 for Resident #24 revealed an order for Duke's Magic Mouthwash with viscous Lidocaine 2%. She has an order to take 10 ml before each meal and at bedtime for tongue pain due to a mass. Resident #24 received 57 doses of the expired medication, Duke's Magic Mouthwash with viscous Lidocaine 2% per the Medication Administration Record for March 2018. On 3/23/18 at 10:25 am an interview with Nurse # 4 revealed Resident #24 had been receiving the medication and this was the only bottle available. She stated she had not noticed the medication was out of date. On 3/23/18 at 3:40 pm an interview with the Director of Nursing revealed her expectation was that no resident would receive an expired medication. She stated the nurses were responsible for checking the medication expiration date before administering the medications. On 3/23/19 at 4:00 pm an interview with the Administrator revealed her expectation was the nurses would check the expiration date of each medication before it is given.	F 761	Current facility residents have the potential to be affected by the alleged deficient practice. Actions to ensure compliance are: Unit Managers completed a 100% cart audit of facility med carts and medication storage areas. Measures put in place to ensure the alleged deficient practice does not re-occur include: Education on monitoring medication expiration, labeling and storage of drugs & biologics will be provided to current nursing staff and new licensed nursing staff during orientation. Education began on March 23rd by Unit Manager . The Director of Nursing or nurse management will perform audits of medication carts and other locations were medications are stored 5 times a week for 4 weeks, then 2 times a week for 4 weeks, then weekly for 4 weeks. The Director of Nursing or nurse management will analyze audits/ reviews for patterns/ trends and report in the Quality Assessment and Assurance committee meeting monthly for 4 months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/ trends identified.	
F 812	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		4/20/18

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	345130	A. BUILDING _____ B. WING _____	C 03/23/2018

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F 812 SS=E	Continued From page 35 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, staff interviews and record review, the facility failed to properly label food stored in walk-in freezer and walk-in refrigerator, failed to discard expired food from walk-in freezer, failed to maintain the walk-in refrigerator safe operating condition and failed to repair the ceiling in the kitchen. Findings included: 1. An observation of foods stored in the kitchen's walk-in freezer on 3/20/18 at 10:12 AM revealed a thin ice formed on and inside the bag of unopened frozen cut zucchini, and had freezer burn. An unopened and unlabeled clear bag that contained 18 pieces of a food that looked like	F 812	Corrective action has been accomplished for the alleged deficient practice in regards to failure to: label food that was stored in walk in freezer and walk in refrigerator, discard expired food, and to maintain the walk in refrigerator in safe working conditions. Dietary staff is responsible for inspecting all food stored in walk in freezer and walk in refrigerator including the disposal of expired foods. The dietary staff discarded, undated improperly labeled or expired food products. The white porcelain box was removed and contents discarded. The kitchen ceiling was repaired. The walk in refrigerator was repaired immediately by	

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F 812	Continued From page 36 pancakes. An unopened and unlabeled clear bag that contained 18 pieces of a food that looked like French toast. A frozen pie labeled "lemon meringue" with use by date "2/1/18". An Open bag of pancake with no use by date or expiration date on it. An opened and unlabeled bag containing fives pieces of breaded meat. Cook #1 indicated, during the observation, the breaded meat was fish patties. During an interview with the corporate Dietary Manager (DM) on 3/20/18 at 10:40 AM, she indicated that all opened food packages should be properly labeled and expired food discarded appropriately. During an interview with the administrator 03/23/18 at 4:42 PM, She stated it was her expectation that staff labeled food appropriately and discard expired food. 2. An observation of foods stored in the kitchen's walk-in refrigerator on 3/20/18 at 10:12 AM revealed an aluminum pan with cling wrap, and "Mac and cheese, 3/16/18 "written on it. A transparent plastic container containing brown colored food with "Choco pudding, 3/16/18" written on it. A big aluminum pan with an aluminum foil with "Beef roast, 3/14/18" written on it. A plastic container containing yellowish colored food, covered with cling wrap with "Corn, 3/14/18 "written on it. A grocery bag that contained a white porcelain food container with brown colored food inside. No label or date on the bag. Review of the food storage policy revealed food prepared and held for more than 24 hours at a temperature of 5 degree centigrade (41 degrees Fahrenheit) should be marked to indicate the date or day by which food should be consumed or	F 812	the Maintenance Director. Dietary staff observed walk in refrigerator and walk in freezer completed an inspection on all food in walk in refrigerator and walk in freezer. Date completed 3/20/2018. Education and instructions provided dietary staff members by the District Manager, on the topic of proper food storage and sanitation. This was completed on 3/20/2018. To ensure the deficient practice does not reoccur,the dietary manager or designee will perform a daily audit 5 times a week for 4 weeks on the sanitation and food storage then bi weekly for 4 weeks, then monthly for 3 months. The audit will be signed at the time of inspection. The dietary manager or designee will provide copies of the audit to the administrator on Fridays by 5 pm. The audits will be submitted to the QAPI and performance will be reviewed by QAPI committee to determine the need of ongoing audits.	

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F 812	Continued From page 37	F 812		

discarded. Policy also indicates that food can be stored for maximum 7 days and day of preparation should be counted as Day 1.

During an interview with the dietary cook #1 on 3/20/18 at 10:20 AM, she indicated leftover foods were labeled and left in the refrigerator for 3 days from the date indicated on the label. She indicated that the cooks were responsible to check leftover's and discard any food that was more than 3 days old.

During an interview with the corporate Dietary Manager (DM) on 3/20/18 at 10:40 AM, she indicated that the facility DM had resigned earlier in February 2018 and she has been the DM since. She indicated she was unsure of the date and implementation of the policy, but indicated that the new policy was for leftover foods to be discarded within 7 days and not 3 days. She further stated that staff should use the appropriate labels to indicate the preparation date and use by date.

During an interview with Dietary cook # 2 on 3/22/18 at 1:50 PM, Cook indicated that the leftover foods were labeled with a label which indicated the date of prep and use by date. She indicated food leftovers were discarded within 3 days from the day of preparation. She also stated if a label was not placed and only a date was written then it was the preparation day and food was discarded within 3 days.

During an interview with the corporate DM on 3/23/18 at 1:30 PM she indicated the bag containing white porcelain box belonged to a resident that was brought in by the family and staff had accidently placed the food in the

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F 812	Continued From page 38	F 812		

refrigerator instead of the nourishment refrigerator. She indicated the food should be labeled and dated before been placed in the refrigerator.

3. An observation of the kitchen's ceiling on 3/20/18 at 10:25 AM revealed approximately 1 to 1 and ½ foot long (linear) area of plaster peeling above the walkway near the stove, approximately 18 x 18 inch square ceiling near the dish washer where the dirty dishes were stored and a grapefruit size patch of ceiling peeling around the pipes near the stove.

During an interview with the corporate DM on 3/20/17 at 10:40 AM, she indicated that the kitchen had some maintenance issues that needed to be fixed. She indicated that they were waiting for maintenance to fix the refrigerator and ceiling in the kitchen. She also stated due to recent rains (previous week) the ceiling was leaking and was being repaired.

During an interview on 03/23/18 at 2:44 PM, with Maintenance Director stated the sheet rock had buckled and ceiling had peeled due to heavy rains. He stated a flat roof membrane was applied over the patches. He was unsure of the date when the incident happened.

During an interview on 03/23/18 at 4:42 PM, Administrator indicated the night prior to survey the heavy rains had caused damage and the maintenance could only repair it in the evening. She indicated the ceiling was in a process of being repaired.

4. An observation of the walk-in refrigerator on 3/20/18 at 10:12 AM also revealed a plastic

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F 812	Continued From page 39 container under the refrigerator compressor that had water which was dripping from a pipe below the compressor. An aluminum pan with silver foil labelled Beef roast and dated 3/14/18 was stored in close proximity of the container. During an interview with the dietary cook #1 on 3/20/18 at 10:20 AM, cook# 1 indicated a plumber was needed to fix the pipe so that it stops dripping. She indicated that maintenance staff was aware of the issue. Cook #1 further stated that dietary staff should be cleaning the refrigerator floor daily. During an interview with the corporate DM on 3/20/18 at 10:40 AM, She indicated was unsure why the cook stated that a plumber was needed to fix the refrigerator. She stated it was maintenance work that has been pending for some days. During an interview with Maintenance Director on 03/23/18 at 2:44 PM, he stated work order for kitchen was made by word of mouth as dietary staff did not have access to work order request on the computer. He indicated work order regarding the dripping pipe in the refrigerator was placed (unsure of the date) and was repaired on Wednesday 3/21/18. During an interview on 03/23/18 at 4:42 PM, Administrator indicated that the maintenance staff was not made aware of the refrigerator's leaking pipe and the issue was fixed it immediately when notified.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information.	F 842		4/20/18

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F 842	Continued From page 40	F 842		

(i) A facility may not release information that is resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

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F 842	Continued From page 41 §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain accurate medical records for one of seven residents reviewed for unnecessary medications (Resident #18). The findings included: Resident #18 was admitted to the facility 3/14/17. Cumulative diagnoses included Crohn's disease, diabetes, generalized anxiety, insomnia, peripheral vascular disease, seizures, bipolar disease and major depressive disorder. A Quarterly Minimum Data Set dated 1/5/18	F 842	Resident #18's physician was notified of the medication omission by the nurses and the documentation discrepancy related to Clonazepam documented as administered instead of medication was not available for administration on 3/22/2015. Resident #18 is his/ her own responsible party and was aware of the documentation discrepancy. The resident was assessed by the physician on 3/22/2018 with out adverse effects noted. Education was provided to the nurse by the Unit Manager on 3/22/2018 regarding	

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F 842	Continued From page 42 indicated Resident #18 was cognitively intact. Medications administered during the assessment period included 7 days of antipsychotic, antianxiety, antidepressant and diuretic medication and 1 day of opiod medication. A review of the physician orders revealed an order for Resident #18 dated 2/20/18 for clonazepam (anti-anxiety medication) 0.5 milligrams-- give one tablet every bedtime for seizures. A review of the Medication Administration Record (MAR) for March 2018 revealed clonazepam was not administered to Resident #18 on 3/16/18, 3/18/18,3/19/18 and 3/20/18. The medication was documented on the MAR as having been administered on 3/17/18. A nursing note dated 3/17/18 at 9:05 PM by Nurse #6 stated clonazepam tablet 0.5 milligrams. Give 1 tablet by mouth at bedtime for seizures. Medication was on order from pharmacy. On 3/22/18 at 3:54 PM, an interview was conducted with Nurse #6. She reviewed the MAR for 3/17/18 and stated she had documented that the clonazepam had been administered but the nursing note dated 3/17/18 stated the medication was on order from the pharmacy. She stated she must have marked the wrong block and the medication was not available. On 3/22/18 at 4:08 PM, an interview was conducted with the Assistant Director of Nursing who stated she expected the MAR to be accurate and the medication should only be marked if given.	F 842	accuracy of documentation. Current facility residents who receive medications have the potential to be affected by the alleged deficient practice. Licenses nurse will be provided education related to the importance of ensuring documentation related to medication administration accurately reflects whether medication was administered as ordered of if for some reason was not including the reason it was not. Education will be provided by the Director of Nursing, Nursing Supervisor or Unit Managers beginning March 22, 2018 and will continue until current staff has been trained. Newly hired nurse will receive training during orientation. The DON, Unit Managers, Supervisors or other designated licensed nurse will audit the Medication Administration Records for 5 residents at least 5 times weekly x 4 weeks, then 2 residents daily at least 5 times weekly x 2 weeks, then 2 residents weekly x 2 weeks to ensure documentation for medication administration is present and completed accurately. The Director of Nursing will be responsible for the implementation for the acceptable plan of correction for completion and accuracy of residents MAR□s. The Director of Nursing and or Unit Manager will review and analyze audits and reports in QAPI meeting monthly. The QAPI committee will make	

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F 842	Continued From page 43	F 842	recommendations based off of trends identified.	
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain one of one walk-in refrigerator in safe operating condition. Findings included: An observation of the walk-in refrigerator on 3/20/18 at 10:12 AM revealed a plastic container under the refrigerator's compressor that had water dripping from a pipe below the compressor. During an interview with the dietary cook #1 on 3/20/18 at 10:20 AM, she indicated plumber needed to fix something in the refrigerator so that it stops dripping. She indicated that maintenance was aware of the issue. During an interview with the Dietary Manager (DM) on 3/20/18 at 10:40 AM, she indicated was unsure why the cook stated that plumber needed to fix the refrigerator. She indicated that the kitchen had some maintenance issues that needed to be fixed. She indicated that they were waiting for maintenance to fix the problems in the kitchen. The kitchen had ceiling plaster peeling off at some place and she was referring to the both refrigerator and ceiling repairs that maintenance needed to work on.	F 908	F 908: The facility allegedly failed to maintain the walk in refrigerator in safe operational condition. Maintenance Director repaired the issue of water dripping from pipe on 3-20-2018. Current residents have a potential to be affected by the deficient practice. The procedure for implementing the acceptable plan of correction for this deficiency cited. Maintenance Director immediately repaired the issue of water dripping from pipe on 3-20-2018. Education and instructions provided to the dietary staff by district manager on the procedure of notifying the Maintenance Director when essential equipment is not operating appropriately. This was started on 3/20/2018. The monitoring procedure to ensure the plan of correction is effective and the specific deficiency cited remains corrected and or/ in compliance with regulatory requirements. To ensure the deficient practice does not continue the Maintenance Director or Maintenance Assistant will perform daily	4/20/18

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F 908	Continued From page 44 During an interview with Maintenance Director on 03/23/18 02:44 PM , he stated the work order for kitchen was made by word of mouth as dietary staff did not have access to work order request on the computer. He indicated work order regarding the dripping pipe in the refrigerator was placed (unsure of the date).	F 908	audits 5 times a week for 4 weeks, then monthly for 3 months. The Audit will be signed at the time of inspection to ensure essential equipment is in safe operating condition. The Administrator will review the audits, reporting to the QAPI committee monthly x 3 months. The committee will make recommendations based on trends indemnified to achieve continued compliance.	