STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(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 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. This REQUIREMENT is not met as evidenced by: Based on resident and facility staff interviews, the facility failed to honor the food choice of 1 of 12 residents (Resident #5) who preferred softly cooked fried eggs for breakfast. Findings included:	F 561	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of	4/16/18

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

Electronically Signed | 04/12/2018

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F 561	Continued From page 1 The facility's policy on "Production, Use of Pasteurized Egg Products" (revised 9/2014) included: "If a resident insists upon a fresh shell egg, cooked to less than fully cooked, pasteurized shell eggs are to be purchased and used." Resident #5 was admitted to the facility on 9/21/17 with diagnoses which included multiple sclerosis, hyperlipidemia and atherosclerotic heart disease. Review of the Physician's Order dated 9/21/17 revealed Resident #5 was to receive a regular diet of regular texture and thin consistency. The Nutrition Assessment dated 12/28/18 documented Resident #5 was independent with eating and ate his meals in the dining room. The resident's intake was adequate, consuming 75-100% of most of his meals. The resident's weight was stable with no nutritional concerns at the time of the assessment. The most recent quarterly Minimum Data Set (MDS) dated 12/29/17 indicated Resident #5 was cognitively intact and required supervision with set-up assistance with eating. During an interview in the main dining room on 03/20/18 at 9:14 a.m., Resident #5 stated that the facility did not serve a variety of food, especially at breakfast. The resident expressed dissatisfaction in only receiving scrambled eggs every day at breakfast because no other form of eggs were offered. Resident #5 stated that he preferred and had requested 2-"sunnyside-up" fried eggs, but always received powdered,	F 561	Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F561 SELF-DETERMINATION. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; The facility failed to honor the food choice of 1 of 12 resident (Resident #5) who preferred softly cooked fried eggs for breakfast. Resident #5. Facility has promoted and facilitated resident self-determination through support of resident food choice of 2 "sunnyside-up" fried eggs at breakfast. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; On 3/24/18, the dietary department manager ensured to promote and facilitate residents' honored food choice in reference to the facility's policy on "Production, use of Pasteurized Egg Products" for residents who had a preference and whose diets allowed. On 3/26/18 the Dietary Manager began in-serving the Dietary Department that the facility has to promote and facilitate residents' self-determination through support of residents' food choice in reference to the facility's policy on "Production, use of Pasteurized Egg Products" for residents who have a preference and whose diets allow. Also , that the residents have a right to choose	

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F 561	Continued From page 2 scrambled eggs. The resident revealed stated that he once purchased fresh eggs, and requested the dietary department prepare fried eggs for him, but dietary refused. During an interview on 03/21/18 at 12:09 p.m., the DM (Dietary Manager) revealed the facility's dietary department only purchased liquid eggs and cooked, boiled eggs. The DM stated that it was Corporate's policy to only serve thoroughly cooked eggs; fresh raw eggs were not purchased by the facility. The DM acknowledged Resident #5 had requested fried eggs and was informed the company did not purchase fresh, raw eggs for safety reasons. The DM revealed she had prepared the resident omelets made prepared from liquid eggs which the resident enjoyed. The DM also stated that the dietary department was not allowed to bring food into the kitchen from outside sources. On 03/21/18 at 2:50 p.m., after reviewing the facility's policy on the "Production, Use of Pasteurized Egg Products", the DM acknowledged she was incorrect in her earlier interview concerning not purchasing and serving shell eggs. She stated that the facility's policy did allow for the purchase of pasteurized eggs, only. The DM indicated she would immediately begin purchasing and preparing pasteurized shelled eggs for residents who prefer them and whose diets allowed. She stated that she would inform Resident #5 of this change.	F 561	activities, schedules (including sleeping and waking times), health care providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. The resident have a right to make choices about aspects of his or her life in the facility that are significant to the resident. The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. 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. As of 4/16/2018 no dietary department employee will be allowed to work until the training has been completed. Effective 4/16/2018, this training is incorporated into the new employee orientation program. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Dietary Department Manager will start interviewing 5 alert and oriented residents on April 20, 2018 using a quality assurance (QA) survey tool to	

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F 561	Continued From page 3	F 561	ensure that the facility is promoting and facilitating residents honored food choice for residents who had a preference and whose diets allowed. This will be done for 4 weeks then monthly for 3 months. Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly QA Meeting is attended by the Director of Nursing, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: April 16, 2018	
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in	F 623		4/16/18

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F 623	Continued From page 4 paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal	F 623		

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F 623	Continued From page 5 hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).	F 623		

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F 623	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on resident, family and staff interviews and record review, the facility failed to provide the resident and resident representative a written notification for the reason for transfer to the hospital and did not send a copy of the notice to the Ombudsman for 1 of 2 residents (Resident #7) reviewed for hospitalization. Findings included: Resident #7 was admitted to the facility on 10/22/16 with diagnoses that included, in part, chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF). A review of the most recent comprehensive minimum data set (MDS) assessment dated 7/20/17 revealed Resident #7 had moderately impaired cognition. A review of a quarterly MDS assessment dated 1/12/18 revealed Resident #7 was cognitively intact. A review of the medical record revealed Resident #7's representative was a family member. A review of the medical record revealed Resident #7 was transferred to the hospital on 1/3/18 for chest pain. The resident was re-admitted from the hospital to the facility on 1/5/18. She was transferred again to the hospital on 2/13/18 for shortness of breath and re-admitted back to the facility on 2/16/18. No written notice of transfer was documented to have been provided to the resident, resident representative or Ombudsman. On 3/22/18 at 8:37 AM an interview was completed with Resident #7. She stated when	F 623	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F623 NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; The facility failed to provide the resident and resident representative a written notification for the reason for transfer to the hospital and did not send a copy of the notice to the Ombudsman for 1 of 2 residents (Resident #7) reviewed for hospitalization. Resident #7. Resident is currently in facility. Facility sent a copy of the notice to a Long-Term Care Ombudsman as required as this was not being done during the prior months. A record of the reasons for discharge or transfer are in the resident's medical record. The facility failed to ensure the notice was sent to the resident and/or resident representative because the regulation was not being followed by the facility. The procedure for implementing the	

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F 623	Continued From page 7 she transferred to the hospital in both January and February she did not receive a written notice of transfer/discharge from the facility. On 3/22/18 at 10:58 AM an interview was completed with the Administrator. She said she had been at the facility for about three weeks and reported that transfer/discharge notices were not sent to the Ombudsman. On 3/22/18 at 12:14 PM an interview was completed with Resident #7's representative. He reported he did not receive a written notice of transfer/discharge when the resident transferred to the hospital on both 1/3/18 and 2/13/18. On 3/22/18 at 12:26 PM an interview with the Administrator revealed that notices of transfer/discharge should be sent to the resident and/or resident's representative when a resident is transferred to the hospital. The Administrator stated notices had not been sent prior to her coming to the facility in March but that they should have been completed and residents/resident representatives notified when transferred to the hospital. She further stated notices should have also been sent to the Ombudsman's office and she would begin sending copies of the transfer/discharge notices to the Ombudsman on a monthly basis.	F 623	acceptable plan of correction for the specific deficiency cited; On 4/4/2018, the Administrator ensured that a notification was made to the resident and the resident's representative (s) for all residents who were transferred or discharged and the facility send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. 4/10/2018, the Staff Development Coordinator in serviced the Director of nursing, Social Worker, Business office Manager, Health Information Manager, all Nurses (Registered Nurses, License practical Nurse: Full time, Part time and PRN) and Admissions department that before a facility transfers or discharges a resident, the facility must: notify the resident and the resident's representative (s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-term Care Ombudsman; Record the reasons for the transfer or discharge in the resident's medical record. The notice of transfer or discharge required must be made by the facility at least 30days before the resident is transferred or discharged. The notice must be made as soon as practicable before transfer or discharge when the safety of individuals in the facility would be endangered, the president's health improves sufficiently to allow a more immediate transfer or discharge, an	

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F 623	Continued From page 8	F 623	immediate transfer or discharge is required by the resident's urgent medical needs and a resident has not resided in the facility for 30days. The written notice must include the reason for transfer or discharge, the effective date of transfer or discharge, the location to which the resident is transferred or discharged, a statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests ; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request, the name, address (mailing and email) and telephone number of the Office of the State Long-term Ombudsman. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. In the case of facility closure, the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the Long-Term Care Ombudsman, resident of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents. As of 4/16/2018 interdisciplinary team member will not be allowed to work until the training has been completed. Effective 4/16/2018, this training is incorporated into the new employee orientation program. This information has been	

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F 623	Continued From page 9	F 623	integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; Starting 4/20/18 the Administrator will review each transfer/discharge weekly using a quality assurance (QA) survey tool to ensure that the resident, resident representative(s) have been notified of the transfer or discharge, that the facility has send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman as required, and that there is a record of the reasons for the transfer or discharge in the resident's medical record. This will be done for 4 weeks then monthly for 3 months. Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly QA Meeting is attended by the Director of Nursing, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator The title of the person responsible for implementing the acceptable plan of correction;	

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F 623	Continued From page 10	F 623	Administrator and /or Director of Nursing. Date of Compliance: April 16th 2018	
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on resident, family and staff interviews and record review, the facility failed to provide the resident and resident representative a written	F 625	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the	4/16/18

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F 625	Continued From page 11 notification of the bed hold policy upon a resident's transfer to the hospital for 1 of 2 residents (Resident #7) reviewed for hospitalization. Findings included: Resident #7 was admitted to the facility on 10/22/16 with diagnoses that included, in part, chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF). A review of the most recent comprehensive minimum data set (MDS) assessment dated 7/20/17 revealed Resident #7 had moderately impaired cognition. A review of a quarterly MDS assessment dated 1/12/18 revealed Resident #7 was cognitively intact. A review of the medical record revealed Resident #7's representative was a family member. A review of the medical record revealed Resident #7 was transferred to the hospital on 1/3/18 for chest pain. The resident was re-admitted from the hospital to the facility on 1/5/18. She was transferred again to the hospital on 2/13/18 for shortness of breath and re-admitted back to the facility on 2/16/18. Further review of the medical record revealed there was no written notice of the bed hold policy provided to the resident or resident representative when she was transferred to the hospital. On 3/22/18 at 8:37 AM an interview was completed with Resident #7. She stated when she transferred to the hospital in both January and February she did not receive a written notice of the facility's bed hold policy, nor was she	F 625	alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F625 NOTICE OF BED HOLD POLICY BEFORE/UPON TRANSFER. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; The facility failed to provide the resident and resident representative a written notification of the bed hold policy upon a resident's transfer to the hospital for 1 of 2 residents (Resident #7) reviewed for hospitalization. Resident #7. Resident is currently in facility. All residents currently in the facility, who, within the last 30 days since March 1st had been transferred to the emergency room or to an acute care hospital received a copy of the bed hold policy. The facility failed to ensure the policy was sent with the resident because the regulation was not being followed by the facility. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; On 4/10/2018, the Administrator ensured that the facility provided a written notice of bed hold policy and return to the resident or resident representative for all transfers	

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F 625	Continued From page 12 contacted and asked if she wanted to hold her bed at the facility. On 3/22/18 at 11:50 AM an interview was completed with Nurse #2 who was on duty when Resident #7 transferred to the hospital on 2/13/18. She stated when Resident #7 transferred to the hospital she called the resident's representative and informed him of the transfer but didn't send any information with the resident or to the resident's representative related to the bed hold policy. On 3/22/18 at 12:14 PM an interview was completed with Resident #7's representative. He reported he did not receive a written notice of the facility's bed hold policy and said nobody from the facility called him and asked if he wanted to hold Resident #7's bed until she returned from the hospital. On 3/22/18 at 1:29 PM an interview was completed with the Director of Admissions. She said that a copy of the bed hold policy was supposed to be sent with a resident when they transferred to the hospital. She further stated that because the facility had plenty of beds, "We can admit them back. We haven't needed to follow up with residents and resident representatives because we are able to hold that bed until they come back." On 3/22/18 at 1:55 PM a follow up interview with the Director of Admissions revealed that a copy of the bed hold policy was not sent with Resident #7 when she transferred to the hospital on 1/3/18 and 2/13/18. On 3/22/18 at 2:59 PM an interview with the	F 625	or discharges for the month. 4/10/2018, the Staff Development Coordinator in serviced the Director of nursing, All Nurses (Registered nurse, license practical nurse: Full time, Part and PRN) Social Worker, Business office Manager, Health Information Manager and Admissions department that before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies : the duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility, the reserve bed payment policy in the state plan if any, the nursing facility's policies regarding bed-hold periods which must be consistent with permitting a resident to return. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy. As of 4/16/2018 interdisciplinary team member will not be allowed to work until the training has been completed. Effective 4/16/2018, this training is incorporated into the new employee orientation program. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and	

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F 625	Continued From page 13 Administrator revealed that she expected the bed hold policy information be sent to the resident and/or resident's representative when a resident was transferred to the hospital.	F 625	will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; Starting 4/20/18 the Administrator will review each transfer/discharge weekly using a quality assurance (QA) survey tool to ensure that the facility provided a written notice of bed hold policy and return to the resident or resident representative for all transfers or discharges. This will be done for 4 weeks then monthly for 3 months. Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly QA Meeting is attended by the Director of Nursing, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: April 16th 2018	
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning	F 655		4/16/18

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F 655	Continued From page 14 §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.	F 655		

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F 655	Continued From page 15 (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews the facility failed to complete an individualized baseline care plan for three of four sampled new admissions. (Residents #46, 30 and 304). The findings included: 1. Resident #46 was admitted to the facility on 2/27/18 with diagnoses that included fall with fracture left hip and first lumbar vertebrae, pressure ulcer on the sacrum, unspecified psychosis, hallucinations, anxiety, and urinary tract infection. Record review revealed no baseline care plan for the resident. Interview with the Director of Nursing on 3/21/18 at 4:20 PM revealed the floor nurses were supposed to expand on the computer goal and make it individualized for the resident for a care plan. The nurse was supposed to do a care plan on admission, and not just give the initial orders to the resident/responsible party (RP). Interview with MDS Nurse #1 on 03/21/18 at 9:13 AM revealed the floor nurse who did the admission would be responsible for completing the baseline care plan. It would include goal summaries, what the resident was admitted for and admission orders. She explained one copy would be given to the resident, the other copy would be in the chart. Interview with Nurse #1 on 3/21/18 at 3:25 PM revealed she printed off a copy of the physician orders, but did not do a care plan and explained	F 655	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F655 BASELINE CARE PLAN. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; The facility failed to complete an individualized baseline care plan for three of four sampled new admissions. (Residents #46, 30 and 304). Resident #46. Resident individualized comprehensive care plan is developed and summary provided to the resident and their representative. Resident #30. Resident individualized comprehensive care plan is developed and summary provided to the resident and their representative. Resident #304. Resident individualized comprehensive care plan is developed and summary provided to the resident and their representative. The procedure for implementing the acceptable plan of correction for the	

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F 655	Continued From page 16 the MDS nurses did the care plans. She explained the admission orders were given to the resident and/or RP and they signed indicating it was received. She further explained, the one goal on the orders, was a "batch" type order that auto populated when admission orders were put in the computer. 2. Resident #30 was admitted to the facility on 3/4/18 with diagnoses that included Influenza Type B, fall with minor injuries, cystitis, diabetes type 2, hypertension, and a wound on his big toe. Record review revealed no baseline care plan for the resident. Review of the admission orders revealed treatment with an antibiotic for a bladder infection was in process, treatment for Influenza B, wound treatment to the toe and medications. A "Goal to maintain safety and comfort during transition to skilled nursing facility. Pain management as needed. Therapy and behavioral services as ordered by physician" was included in the admission orders. Observations on 3/19/18 at 10:30 AM revealed Resident #30 was on contact precautions. On 3/19/18 at 10:46 AM an interview was conducted with Resident #30. The resident explained he had not been to a care plan meeting since he was admitted. Interview with the Administrator on 3/21/18 at 10:29 AM revealed the facility had not completed the baseline care plan for the resident. She explained this was an area that had been	F 655	specific deficiency cited; On 4/10/2018, the Director of Nursing, MDS (Mini Data Set) coordinators and Unit Managers ensured that an individualized baseline care plan was developed for all new admissions within 48hours of a resident's admission and / or a comprehensive care plan in place of the baseline care plan is developed for all new admissions within 48hours of the residents admission and that the summary of the baseline care plan or comprehensive care plan is provided to the resident and their representative. 4/10/2018, the Staff Development Coordinator in serviced the MDS Coordinators, Director of Nursing, unit Manager, Administrator, Director of nursing, All Nurses (RN, LPN: Full time, Part and PRN) Social Worker, Therapy Director and Dietary Manager that the facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality of care. The base line care plan must be developed within 48 hours of a resident's admission, include the minimum healthcare information necessary to properly care for a resident including but not limited to initial goals based on admission order, physician orders, dietary orders, therapy services, social services and PASARR recommendation if applicable. The facility may develop a comprehensive care plan in place of the baseline care plan if the	

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F 655	Continued From page 17 identified through the Quality Assurance (QA) process and she was in the process of implementing plans for correction. 3. Resident #304 was admitted to the facility on 2/15/18 with diagnoses including fall with fractures of the right hand, right shoulder and neck vertebrae. She had a history of stroke, Parkinson ' s disease and was admitted with a feeding tube for total nutrition and an indwelling urinary catheter. Record review revealed no baseline care plan for the resident. Review of the admission orders dated 2/15/18 included nutrition by a gastrostomy tube, non-weight bearing of the right arm, pain medication, medications for congestive heart failure, and use of an indwelling urinary catheter. The orders included a "Goal to maintain safety and comfort during transition to skilled nursing facility. Pain management as needed. Therapy and behavioral services as ordered by physician." Interview with the Director of Nursing on 3/21/18 at 4:20 PM revealed the floor nurses were supposed to expand on the computer goal and make it individualized for the resident for a care plan. The nurse was supposed to do a care plan on admission, and not just give the initial orders to the resident/responsible party (RP). Interview with MDS Nurse #1 on 03/21/18 at 9:13 AM revealed the floor nurse who did the admission would be responsible for completing the baseline care plan. It would include goal summaries, what the resident was admitted for and admission orders. She explained one copy would be given to the resident, the other copy	F 655	comprehensive care plan is developed within 48hours of the resident's admission. The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to the initial goals of the resident, a summary of the resident's medications and dietary instructions, any services and treatments to be administered by the facility and personnel acting on behalf of the facility, any updated information based on the details of the comprehensive care plan. On admission or within the first 48 hours of admission, the admitting charge nurse will provide the resident and/or the resident representative a written summary of the baseline care plan. The charge nurse and resident and/or resident representative will sign the written summary of the baseline care plan. The charge nurse will give a copy of the signed baseline care plan summary to the resident and/ or resident representative and the original will be placed in the residents medical record. As of 4/16/2018 any employee who was required to be in serviced will not be allowed to work until the training has been completed. Effective 4/16/2018, this training is incorporated into the new employee orientation program. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that	

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F 655	Continued From page 18 would be in the chart. Interview with Nurse #1 on 3/21/18 at 3:25 PM revealed she printed off a copy of the physician orders, but did not do a care plan and explained the MDS nurses did the care plans. She explained the admission orders were given to the resident and/or RP and they signed indicating it was received. She further explained, the one goal on the orders, was a "batch" type order that auto populated when admission orders were put in the computer.	F 655	the change has been sustained. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; Starting 4/20/18 the Director of nursing or Unit Manager will review all admissions during daily clinical meeting (Monday through Friday) using a quality assurance (QA) survey tool to ensure that an individualized baseline care plan was developed for all new admissions within 48hours of a resident's admission and / or a comprehensive care plan in place of the baseline care plan is developed for all new admissions within 48hours of the residents admission and that the summary of the baseline care plan or comprehensive care plan is provided to the resident and their representative. This will be done for 4 weeks then monthly for 3 months. Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly QA Meeting is attended by the Director of Nursing, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: April 16th 2018	

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F 689	Continued From page 19	F 689		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff and family interview and record review the facility failed to provide supervision during meals for a resident that was at risk for choking due to swallowing problems for one of one residents on aspiration precautions. Resident # 30. The findings included: Resident #30 was admitted to the facility on 2/15/18 with a history of a fall with fractures of the shoulder, back and hand, dysphagia, Parkinson ' s disease and dementia. Review of the admission orders dated 2/16/18 indicated Resident #30 received total nutrition by a tube feeding via a gastrostomy tube and was NPO (nothing by mouth.). Review of the speech evaluation dated 2/16/18 indicated Resident #30 had severe oral pharyngeal dysphagia with silent aspiration. The resident was on speech therapy caseload from 2/15/18 to 3/17/18. The Admission Minimum Data Set dated 2/22/18	F 689	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F689 FREE OF ACCIDENT HAZARDS/SUPERVISION /DEVICES. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; The facility failed to provide supervision during meals for a resident that was at risk for choking due to swallowing problems for one of one residents on aspiration precautions Resident #30. Resident #30. Resident is at risk for choking due to swallowing problems and is on aspiration precautions. Resident was	4/16/18

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F 689	Continued From page 20 indicated Resident #30 had long and short- term memory impairment, required extensive assistance of two staff for activities of daily living, and received nutrition and hydration by a feeding tube. Review of the care plan dated 2/22/18 included a problem of nutrition by a feeding tube with approaches for staff to keep the head of the bed elevated, nectar thick liquids and observe for aspiration. An order was written by Speech Therapist #1, dated 3/8/18 for a diet, of puree (dysphagia pureed) texture, nectar consistency (liquids). Instructions included for the resident to be fed in the dining room with supervision, sit upright, and alternate small bites with sips. Review of a speech therapy note dated 3/16/18 revealed Resident #30 she was found to have no sensation at the oral pharyngeal phase. A CT scan revealed an old stroke was present and ruled out a new stroke. A trial of thin liquids revealed a delayed swallow. The speech therapist recommended the resident remain NPO and trials to be done by speech therapy only. Record review of nurse ' s notes dated 3/16/18 revealed the resident went to the emergency room due to abdominal pain. The feeding tube was removed. Review of the speech therapy recertification evaluation for the dates of 3/16/18 to 4/14/18 revealed the resident ' s current functional level included nectar thick liquids and puree consistency foods and she required verbal and visual cues for eating/drinking safely.	F 689	assessed by registered nurse and no signs of aspiration were noted. Resident was supervised during all meals by facility nursing staff. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; On 4/11/2018, the Director of Nursing and Unit Managers ensured that all residents who were at risk for choking due to swallowing problems were supervised during all meals by facility staff. On 4/10/2018, the Staff Development Coordinator in serviced all Nursing staff (Registered Nurses, Licensed practical nurse, Med Techs and Nurse Aides: Full time, Part time and PRN) that the facility must ensure that the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents. And that all residents who are at risk for choking due to swallowing problems or on aspiration precautions must be supervised during all meals by facility nursing staff. As of 4/19/2018 any employee who was required to be in serviced will not be allowed to work until the training has been completed. Effective 4/19/2018, this training is incorporated into the new employee orientation program. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that	

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F 689	Continued From page 21 Observations on 3/20/18 at 11:45 PM revealed Resident #30 was seated in the dining room with a family member. There were no staff in attendance in the dining room during this observation. Observations of the food and drink revealed she had thin liquids, small cubes of meat with noodles on her tray. The tray ticket indicated the nectar thick liquids were marked through and thin liquids was written on the ticket. The diet of puree was marked through. Observations of the resident revealed she coughed one time after a sip of the thin liquid. Interview with Speech Therapist (ST) #1 on 3/21/18 at 8:42 AM revealed she had upgraded the diet to mechanical soft a few weeks ago, but Resident #30 had pocketing of the food. She explained ST#2 had worked with her on 3/20/18 and upgraded her to thin liquids. ST#1 explained Resident #30 would receive an upgraded diet under supervision of ST only. Interview with NA #1 on 3/21/18 at 10:30 AM revealed Resident #30 could feed herself after set-up. She ate in the dining room and the staff would keep a check on her, pass trays and then go back and sit with her. During the interview, NA#1 was asked if a family member could stay with her during the meals instead of staff and she replied it would be "OK" and she would check on her. Observations on 3/21/18 at 1:25 PM revealed Resident #30 was in the dining room and was eating lunch. There were no staff with the resident during the meal. A family member was with the resident and she was drinking thin coffee. There was nectar thick coffee on her tray.	F 689	the change has been sustained. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; Starting on 4/20/2018 the Director of nursing or Unit Manager will review 5 residents weekly using a quality assurance (QA) survey tool who are at risk for choking due to swallowing problems or on aspiration precautions to ensure that they are supervised by facility staff during meals. This will be done for 4 weeks then monthly for 3 months. Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly QA Meeting is attended by the Director of Nursing, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: April 19, 2018	

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F 689	Continued From page 22 Interview on 3/22/18 at 1:28 PM with the family member who was with Resident #30 during lunch on 3/20/18 and again on 3/21/18. Interview revealed an aide or nursing staff member had not stayed with her on Tuesday during the lunch meal when he visited. He further explained an aide had not stayed with the resident on this date when she was eating. During interview he explained she could drink the regular coffee. Interview with Nurse #1on 3/21/18 at 2:00 PM revealed Resident #30 had a red napkin which meant she had to be fed by staff. She explained Resident #30 had swallowing precautions. When asked who fed her lunch, Nurse #1 replied the family member had fed her. Interview with ST #2 on 3/22/18 at 2:24 PM revealed the family member had attended therapy sessions in February. She had not specifically provided training for him on swallowing precautions. She was not aware the family member had given the resident thin liquids today at lunch. ST#2 explained she would have said she would be comfortable with him feeding her and assisting until she was informed he gave her thin coffee, even though the thickened was on the tray. Interview with the DON on 3/22/18 at 3:44 PM revealed she would expect staff to stay with the resident due to aspiration risk. She further explained she would not expect the staff to rely on a family member to be with the resident.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690		4/16/18

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F 690	Continued From page 23 §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews, the facility failed to obtain a physician's order and have medical	F 690	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the	

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F 690	Continued From page 24 justification for an indwelling catheter for 1 of 1 (Resident #90) residents reviewed for catheter use. Findings included: Resident #254 was admitted to the facility on 3/8/18 from the hospital with multiple medical diagnosis. The medical record did not indicate a diagnosis for an indwelling catheter. An observation on 3/19/18 at 10:03 AM revealed Resident #254 lying in bed with a drainage bag hanging on bed. An observation on 3/20/18 at approximately 11:30 revealed Resident #254 lying in bed with a drainage bag hanging on bed. An interview with Resident #254 was conducted on 3/19/18 at 10:03 AM. She revealed the catheter was put in when she went to the hospital and she thought it was because of her broken ankle as she was unable to bear weight on her left leg. A medical record review on 3/20/18 at 9:15 AM did not indicate an order for an indwelling catheter. A review of the Admission Minimum Data Set (MDS) assessment dated 3/15/18 revealed it was still in progress at the time of the survey. Resident #254 was cognitively intact. An interview was conducted on 3/22/18 at 10:50 AM with the Unit Coordinator. She revealed the process for a resident that is admitted with an indwelling catheter is to determine the reason or	F 690	alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F690 BOWEL/BLADDER INCONTINENCE, CATHETER, UTI. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; The facility failed to obtain a physicians order and have medical justification for an indwelling catheter for 1 of 1 (Resident #254) residents reviewed for catheter use. Resident #254. MD notified that resident had an indwelling catheter with no physician orders and with no medical justification noted on the medical record. Resident notified of new orders. New orders for indwelling catheter in place on 3/22/2018. Indwelling catheter was discontinued on 3/26/2018 per physician orders and resident notified. The facility missed that the resident had a catheter on admission and an order wasn't entered. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; On 4/10/2018, the Director of Nursing and Unit Managers ensured that all residents who have indwelling catheters have a physician order and a medical justification for the indwelling catheter.	

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F 690	Continued From page 25 diagnosis for the catheter. If no reason, the physician is called to either obtain a diagnosis or get catheter discontinued. A follow up interview was conducted on 3/22/18 at 11:15 AM with the Unit Coordinator. She revealed she was assisting with this resident's admission and completed the admission assessment. She stated she noted the presence of the catheter and educated the resident on the importance of removing it and the possible adverse effects of keeping it in place and the resident refused to have it removed. The Unit Coordinator further revealed there was miscommunication regarding the notification of the physician. An attempt was made to contact the physician on 3/22/18 at 4:30 PM. An interview was conducted on 3/22/18 at 4:15 PM with the Administrator. She revealed residents admitted with catheters should have orders and she would expect the nurse to obtain one.	F 690	On 4/10/2018, the Staff Development Coordinator in serviced all Nursing staff (Registered Nurses, Licensed practical nurse, Med Techs and Nurse Aides: Full time, Part time and PRN) that the facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. For a resident with urinary incontinence based on the residents comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident’s clinical condition demonstrates that catheterization was necessary, a resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident’s clinical condition demonstrates that catheterization is necessary and a resident who is incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. For a resident with fecal incontinence, based on the resident’s comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel received appropriate treatment and services to restore as much normal bowel function as possible. Also that physician orders have to be obtained for all indwelling catheters and have a	

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F 690	Continued From page 26	F 690	medical justification for the use of the catheter. As of 4/16/2018 any employee who was required to be in serviced will not be allowed to work until the training has been completed. Effective 4/16/2018, this training is incorporated into the new employee orientation program. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; Starting 4/20/18 the Director of nursing or Unit Manager will review 5 residents weekly using a quality assurance (QA) survey tool who have indwelling catheter to ensure that they physician orders and also a medical justification for the use of the indwelling catheter. This will be done for 4 weeks then monthly for 3 months. Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly QA Meeting is attended by the Director of Nursing, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator The title of the person responsible for	

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F 690	Continued From page 27	F 690	implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: April 16th 2018	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 758		4/16/18

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F 758	Continued From page 28 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and staff observations the facility failed to complete an assessment for AIMs (Abnormal Involuntary Movement) assessment on admission for two residents receiving antipsychotic medications in a sample of five residents for unnecessary medications. Residents # 46 and 40. The findings included: 1. Resident #46 was admitted to the facility on 2/27/18 with diagnoses that included fall with fracture left hip and first lumbar vertebrae, pressure ulcer on the sacrum, unspecified psychosis, hallucinations, anxiety, and urinary tract infection. Record review revealed an order dated 2/26/18 for an antipsychotic medication, Risperdal 0.5 milligrams 1 tablet two times a day for dementia with behavioral disturbance. Record review revealed an AIMs assessment had	F 758	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F758 FREE FROM UNNEC PSYCHOTROPIC MEDS/PRN USE The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; The facility failed to complete an assessment for AIMs (Abnormal Involuntary Movement) assessment on admission for two residents receiving	

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F 758	Continued From page 29 not been completed upon admission for a baseline assessment for abnormal involuntary movements due to possible side effects from the use of the antipsychotic medication. Interview on 3/22/18 at 10:29 AM with the Director of Nursing (DON) revealed the unit manager usually did the AIMS assessment. She explained the assessment would be completed upon admission if the resident was admitted on an antipsychotic medication. During the interview, the DON explained she had been the unit manager for Resident #46. After becoming the interim DON, her position was not filled. Further interview revealed it would have been her responsibility to complete the AIMs and it was missed due to human error. Interview with the Consulting Pharmacist on 3/22/18 at 4:26 PM revealed she would expect to find an admission AIMs assessment for a new admission with an antipsychotic medication ordered. The purpose would be to have a baseline for a reference for future assessments for abnormal involuntary movements. The medication regime review was completed on 3/14/18 by another consulting pharmacist. 2. Resident # 40 was admitted to the facility on 2/23/18. Diagnosis include, in part, of Dementia and Psychosis. A review of the Admission Minimum Data Set assessment dated 3/2/18 revealed Resident #40 had impaired cognition, exhibited behaviors of screaming or disruptive sounds and refused care.	F 758	antipsychotic medications in a sample of five residents for unnecessary medications. Residents #46 and #40. Resident #46. AIMs (Abnormal Involuntary Movement) assessment completed on 3/22/2018. No abnormalities noted. Resident #40. AIMs (Abnormal Involuntary Movement) assessment completed on 3/22/2018. No abnormalities noted. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; On 3/25/18 and 4/10/18, the Nurse Consultant and Unit Manager ensured that all residents who are receiving antipsychotic medications have an AIMs (Abnormal Involuntary Movement) assessment completed as required. On 4/10/2018, the Staff Development Coordinator in serviced all Nurses (Registered Nurses, Licensed practical nurse: Full time, Part time and PRN) that a psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, anti-psychotic, anti-depressant, anti-aanxiety and hypnotic. The facility must ensure that residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record. Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Resident do not receive	

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F 758	Continued From page 30 Symptoms of psychosis was checked no. Resident #40 required extensive assistance of 1-2 people for her Activities of Daily Living (ADL's). A medical record review revealed Resident #40 was sent to the hospital on 3/5/18 because she pulled out her gastrostomy tube. She returned to the facility the same day and was started on Seroquel 25 milligrams three times a day. A medical record review revealed Resident #40 was seen by the Physician on 3/7/18 for a urinary tract infection, uncontrolled diabetes and uncontrolled behaviors of yelling out. She was started on an antibiotic and the physician noted the resident was on Seroquel. A medical record review revealed a nurses note date dated 3/13/18 indicating "resident consistently yelling throughout the day" and evaluated by the physician with new medication changes. A review of the physician orders for March 2018 revealed a new order on 3/13/18 for Seroquel 50 milligrams three times a day for psychosis, increased from 25 milligrams three times a day. A medical record review revealed Resident #40 was seen by the Physician on 3/14/18 for an acute visit to address behaviors. The Physician noted: "behaviors have tapered since colleague started increased Seroquel yesterday, no yelling and not somnolent today" and "started on Macrobid for urinary tract infection due to being resistant to Cipro". A medical record review did not indicate that an	F 758	psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. PRN orders for psychotropic drugs are limited to 14days except if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14days, he or she should document their rationale in the resident's medical record and indicate the for the PRN order. PRN orders for anti-psychotic drugs are limited to 14days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. An AIMS (Abnormal Involuntary Movement) assessment has to be completed for all residents receiving antipsychotic medication on admission, every six months, and PRN by the Mini Data Set (MDS) Coordinators. As of 4/16/2018 any employee who was required to be in serviced will not be allowed to work until the training has been completed. Effective 4/16/2018, this training is incorporated into the new employee orientation program. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The monitoring procedure to ensure that the plan of correction is effective and that	

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F 758	Continued From page 31 assessment for extrapyramidal side effects had been completed for Resident # 40. An interview was conducted on 3/22/18 at 10:30 AM with the interim Director of Nursing (DON). She was the Unit Manager on the 300/400 halls and her position had not been replaced. She revealed it is the Unit Managers responsibility to complete the assessment for extrapyramidal side effects if a resident is admitted on an antipsychotic and when an antipsychotic is started after admission. The other Unit Manager is covering for both sides and filling in on the hall and the assessment for this Resident #40 got missed. She further revealed the expectation was that the assessment for extrapyramidal side effects be done per the facility policy. An interview was conducted on 3/22/18 at 3:47 with the Administrator. She revealed the facility had not been completing the assessments for extrapyramidal side effects or monitoring antipsychotic drug use per the Quality Improvement Plan.	F 758	specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; Starting 4/20/18 the Director of nursing or Unit Manager will review 5 residents weekly using a quality assurance (QA) survey tool who are receiving antipsychotic medication to ensure that they have an AIMS (Abnormal Involuntary Movement) assessment completed as required. This will be done for 4 weeks then monthly for 3 months. Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly QA Meeting is attended by the Director of Nursing, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: April 16th 2018	
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require	F 865		4/16/18

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F 865	Continued From page 32 disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility's Quality Assessment and Assurance Committee (QA and Q) failed to implement, monitor and revise as needed the action plan developed for the recertification survey dated 2/16/17, in order to achieve and sustain compliance. This was for one recited deficiency on a recertification survey on 3/22/18. The deficiency was in the area of unnecessary medications. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referenced to: F329: The recertification survey on 2/16/17 cited the facility for failure to obtain lab work for monitoring of blood sugars for a resident on insulin in a sample of 5 residents for unnecessary medications. Resident #43 The recertification survey on 3/22/18 cited the facility at F 758 for failure to complete an abnormal involuntary movement (AIMS) assessment for monitoring of two sampled	F 865	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F865 QAPI PRGM/PLAN, DISCLOSURE /GOOD FAITH ATTMPT The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; The facility's Quality Assessment and Assurance Committee (QA and Q) failed to implement, monitor and revise as needed the action plan developed for the recertification survey dated 2/16/2017, in order to achieve and sustain compliance. This was for one recited deficiency on a recertification survey on 3/22/2018. The deficiency was in the area of unnecessary medications. The continued failure of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 03/22/2018

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F 865	Continued From page 33 residents on antipsychotic medications in a sample of 5 residents for unnecessary medications. Residents #40 and 46. Interview with the Administrator on 3/22/18 at 3:47 PM revealed QA meetings were held monthly with review of antipsychotic medications. The QA did not include review of the monitoring using the AIMs assessment to ensure it was completed. The new admissions have not been checked for use of antipsychotic meds and completion of the AIMS.	F 865	facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. This tag is cross referenced to: F329: The recertification survey on 2/16/2017 cited the facility for failure to obtain lab work for monitoring of blood sugars for a resident on insulin in a sampled of 5 residents for unnecessary medications. Resident #43. The recertification survey on 3/22/2018 cited the facility at F758 for failure to complete an abnormal involuntary movement (AIMS) assessment for monitoring of two sampled residents on antipsychotic medications in a sample of residents for unnecessary medications. Resident #40 and 46. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; This tag is cross reference to F758 for failure to complete an abnormal involuntary movement (AIMS) assessment for monitoring of two sampled residents on antipsychotic medications in a sample of residents for unnecessary medications. Resident #40 and 46. On 4/12/2018, The Quality Assurance Nurse in serviced the Administrator in reference to the Quality Assessment and Assurance. A facility must maintain a quality assessment and assurance committee consisting at a minimum of:(i) The director of nursing services;(ii) The Medical Director or his/her designee;(iii)	

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F 865	Continued From page 34	F 865	At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and The quality assessment and assurance committee must :(i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Effective 4/16/2018, this training is incorporated into the new employee orientation program. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; This tag is cross reference to F758 for	

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F 865	Continued From page 35	F 865	failure to complete an abnormal involuntary movement (AIMS) assessment for monitoring of two sampled residents on antipsychotic medications in a sample of residents for unnecessary medications. Resident #40 and 46. Starting 4/20/18, to ensure compliance, Administrator or Director of Nursing will monitor this issue using a quality assurance (QA) survey tool. Facility will monitor compliance of QA for F758. This will be done on weekly basis for 4 weeks then monthly for 3 months by Administrator and reviewed monthly by the Quality Assurance Nurse Consultant to ensure compliance. Reports will be presented to the weekly QA Committee by the Administrator or Director of Nursing to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: April 16th 2018	