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	345006	A. BUILDING ______ B. WING ______	C 03/15/2018

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BLUMENTHAL NURSING & REHABILITATION CENTER	3724 WIRELESS DRIVE GREENSBORO, NC 27455

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E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to have an Emergency Preparedness plan (EP). The EP plan did not include facility and community based risk assessments which includes missing residents, the facilities resident population, a process that includes collaboration with local, regional, state and federal officials. The plan did not have any policy or procedures regarding the emergency plan, the provision of needs for staff and residents, evacuation, sheltering of residents and	E 001	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirement under state and federal law, and to demonstrate	4/27/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 04/06/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 001	Continued From page 1 staff that remain in the facility and the transportation of medical records. The EP plan did not have any documentation regarding arrangements for other facilities to receive patients in the event of evacuation. The communication plan did not address names or contact information for staff, resident ' s physicians or other facilities. The EP plan did not have a way to share information and medical documents of a resident with another facility. The plan failed to have a training program as well as an emergency and standby power system. Findings included: 1A: A record review of the EP manual revealed that the manual did not include a community or facility based risk assessment and strategies. Further review revealed the manual also did not include missing residents in their EP program. B: A further review of the EP manual revealed that the resident population with in the facility was not addressed as well as the residents who needed special care like oxygen and immobility. The plan did not address the type of services the facility was capable of providing to the residents during an emergency situation. The continuity and succession plan was not included in the EP plan and the risk assessment for the facility was not completed. C: The review of the EP manual revealed that there was not any criteria listed for residents or staff who would be sheltered in the facility during an emergency. The EP manual also did not have any procedure for sheltering residents, staff and others who needed to remain in the facility in the event evacuation could not occur.	E 001	the good faith attempts by the provider to improve the quality of life of each resident. E0001 Establishment of the Emergency Preparedness Program 483.73 Root Cause The facility failed to have a comprehensive Emergency Preparedness Plan available to surveyors during the recertification survey. Immediate Action The facilities Emergency Preparedness Program was reviewed by the Administrator on 4/2/18 and it was discovered the Emergency Preparedness Program has some parts that are incomplete. The Administrator will construct all the missing components of the Emergency Preparedness Program and add these components to the Emergency Preparedness book to satisfy CMS regulations. Identification of Persons Affected The Administrator reviewed the current Emergency Preparedness Program and subsequently there are major components of the EP plan missing, it is the Administrator□s conclusion that all residents and staff were at risk. All of the following elements of the EP plan listed	

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E 001	Continued From page 2 D: The EP manual revealed a lack of policies and procedures on how the resident ' s confidentiality would be maintained, how the resident ' s medical record information would be protected and how the resident ' s medical record would be available for continuity of care when evacuated or transferred to another facility during an emergency. E: A record review of the EP manual revealed that the communication plan did not include name and contact information of all the staff working in the facility, name and contact information of the residents physicians and name and contact information of other facilities including but not limited to their sister facility that would be providing care and services to residents during an emergency. F: A review of the communication plan did not include processes or procedures that would indicate how resident information and medical documents would be shared with other facilities and health care providers who would be providing continuity of care for residents who are sheltered by other facilities and at other locations during an emergency situation. G: The EP manual revealed that the communication plan did not have any documentation as to how it would share the emergency plan information with the facilities residents, family members and/or the resident ' s representative. H: A review of the EP manual revealed that there was no training program or testing requirements documented in the plan.	E 001	below will be added to the EP book to ensure 100% compliance with all state and federal regulations: 1) Facility Based Risk Assessment 2) Community based risk assessment which includes missing residents, the facilities resident population requiring special care like oxygen and immobility, a process that includes collaboration with local, regional, state, and federal officials. 3) Policy and procedure for the Emergency Plan. 4) Providing for the needs of staff and residents during an emergency or evacuation, and the sheltering of residents and staff that remain in the facility during an emergency situation. 5) Transfer of medical records. 6) Making arrangements with other facilities to receive patients in the event of an evacuation including the other facilities contact information. 7) Comprehensive communication plan including names and contact information for staff, resident□s physician and/or other participating facilities. 8) Procedure for sharing information and medical documents with another facility. 9) Emergency Preparedness Training during orientation.	

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E 001	Continued From page 3 I: The EP plan did not have information listed as to an emergency or stand by power system in case of a power failure during an emergency situation. An interview with the Administrator on 3/15/18 at 4:30 pm revealed the emergency plan was in place prior to her starting at the facility and she thought it was complete. An interview with the Administrator on 3/15/18 at 7:40 pm revealed it was her expectation that the emergency plan be completed with all the required components.	E 001	10) Emergency Generator power source. Systemic Changes During orientation, all new hires will be educated on the new EP program to ensure understanding of the facilities policies and procedures listed in the EP book. All existing employees will be educated on the facilities policies and procedures in the new EP book and re-educated at a minimum of once per year. Monitoring Process The Administrator will bring the EP book with him/her monthly to the QA meeting so the QAPI team can review the EP book to determine if all required components of EP program are in substantial compliance in the EP book. The Staff Development Coordinator will review training records to ensure all new hires are being trained on the EP program upon hire and that all existing employees are in-serviced at least yearly. The QAPI team will review the EP plan during the monthly meeting for any deficiencies. Any deficiencies identified will be brought to the Administrator□s attention and a QAPI plan will be created to correct and monitor any deficiencies. Responsible Party Effective 4/6/18, the Administrator, Director of Nursing and the Maintenance	

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E 001	Continued From page 4	E 001	Director will be ultimately responsible to ensure execution of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance. The comprehensive Emergency Preparedness plan will be completed, staff in-serviced, and the EP plan will be available to all staff by 4/27/18.	
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen	F 550		4/27/18

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F 550 Continued From page 5
or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observations, record reviews, resident and staff interviews the facility failed to provide incontinence care when requested, resulting in compromised dignity for 1 of 1 resident who required extensive assistance with person hygiene. Resident #373.

Findings included:

Resident #373 was admitted to the facility on 11/17/2017 with current diagnoses of anemia, heart failure, hypertension and diabetes mellitus.

Resident #373 ' s Minimum Data Set (MDS) dated 2/13/2018 revealed Resident #373 was cognitively intact. Resident #373 required extensive assistance with bed mobility, transfer, toilet use, locomotion, dressing and person hygiene with one person physical assist. Resident #373 was incontinent of bladder and bowel.

During an interview with Resident #373 on March 12, 2018 at 9:30am, Resident indicated that last week and just last night she waited 2 hours for

F 550

F550D Residents Rights/Exercise of Rights

ROOT CAUSE

The alleged noncompliance resulted from the CNA # 51 not providing incontinent care when requested to 1 resident #373 on March 12, 2018 on 3 to 11 shift.

IMMEDIATE ACTION

CNA # 51 was interviewed by the Director of Nursing services on April 4, 2018 and stated she does not recall resident #373 call bell being on for 2 hours and stated she always answers her call bells with in 15 minutes and that she treats her residents with dignity and respect. CNA # 51 was educated on the timely answering of call lights and providing timely incontinent care.

IDENTIFICATION OF OTHERS

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F 550 Continued From page 6

staff to change her. She indicated that her call bell was on and an aide came in and cut off her call bell and stated she was not her aide but would find her aide. Resident # 373 stated it was about 7:30pm when she cut on her call bell and around 8:15pm when the aide came in and cut it off. Resident #373 stated she believed she went to sleep and around 9:30pm staff came in and changed her. Resident #373 revealed that this happened weekly. Resident #373 indicated that she felt sad and down a lot in this facility. Resident #373 indicated "that it ' s a very bad feeling to be wet for long period of time but I am use to it now." Also during this interview Resident #373 revealed that she knew how long it took for staff to come and change her because she had a clock above her TV with the correct time on it.

Observation of the clock above Resident #373 ' s TV with the correct time on it.

During an interview with Nursing Assistant(NA) # 51 on March 13, 2018 at 11am for Resident #373 who worked with her on March 12, 2018 during second shift indicated that she does not recall Resident #373 call bell being on for 2 hrs. NA #51 stated she always answered her call bells with 15 minutes and treats her residents with respect and dignity.

During an interview with the Administrator on March 15, 2018 at 10am, she indicated that her expectation was for all staff to answer call bells within 5-7 minutes and provide the treatment needed. Her expectation would be that all staff treat all residents with respect and dignity.

F 550

Starting 4/4/2018 - 4/6/2018 the Director of Nursing Services, Staff Development Coordinator and Unit Coordinator interviewed all residents with a BIMS score of 8 or above, to identify if call lights are being answered timely and incontinent care was being provided timely. This was documented on an interview record and no other residents were identified as having concerns with the timely answering of call lights or the timeliness of providing incontinent care.

SYSTEMIC CHANGES

Starting April 4, 2018 - April 6, 2018 the Director of Nursing Services and or Staff Development Coordinator will complete 100% education for all licensed nurses and certified nursing assistants. This education will include, answering of call lights timely as well as the timeliness of providing incontinent care. This education will be completed by April 6, 2018. Any licensed nurses and certified nursing assistants not educated prior to April 6, 2018 will not be allowed to work until educated.
Effective April 6, 2017 all new hire licensed nurses and certified nursing assistants will receive orientation regarding, the answering of call lights timely as well as the timeliness of providing incontinent care.

MONITORING PROCESS

The Director of Nursing Services, Staff

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F 550	Continued From page 7	F 550	Development Coordinator and or Unit Coordinator will monitor the compliance of answering call lights timely and the timeliness of providing incontinent care by completing a random observation audit. This audit will include a random observation of 10 call lights daily for 2 weeks, then 10 call lights weekly for 2 weeks, then 10 call lights monthly for 3 months or until a pattern of compliance is maintained. Effective April 6, 2018, the Director of Nursing Services will report the finding to the Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure a facility remains in substantial compliance. REPONSIBLE PARTY Effective 4/6/2018 the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	
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:	F 641		4/27/18

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F 641	Continued From page 8 Based on observations, record review, resident and staff interviews the facility failed to accurately code the minimum data set (MDS) assessment for 1 of 1 resident that was reviewed for communication (Resident #112.) Findings Included: Resident #112 was admitted to the facility on 2/7/18 and diagnoses included osteomyelitis, cellulitus of left lower limb, non-pressure chronic foot ulcer, diabetes, and depressive disorder. An admission minimum data set (MDS) dated 2/7/18 for Resident #112 revealed she did not need or want an interpreter, her preferred language was blank and her brief interview for mental status (BIMS) was 13. The care plan dated 2/16/18 for Resident #112 did not identify that the resident had the potential for communication deficits related to her preferred language being Spanish. An interview was attempted with Resident #112 on 3/13/18 at 2:00 pm. The resident was able to say simple phrases such as "Hello" and "Thank You" in English, but primarily spoke Spanish. She was unable to carry on a conversation or answer questions that were asked in English. An interview on 3/14/18 at 2:11 pm with Nurse #1 revealed Resident #112 primarily spoke Spanish but did speak a few English words. She stated Resident #112 was able to communicate most of the time with gestures and Nurse #1 would use her cell phone application to translate the conversation. Nurse #1 added there were several employees that spoke Spanish and she would	F 641	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. F641D Accuracy of Assessments ROOT CAUSE The alleged noncompliance resulted from a care plan dated 2/16/2018 for resident #112 did not identify that the resident had the potential for communication deficits related to her preferred language to speak Spanish and facility failed to accurately code the minimum data set (MDS) IMMEDIATE ACTION On 3/15/2018 MDS Nurse #1 completed a correction to the care plan to include a Spanish as the preferred language and made a correction to the language section of the minimum data set (MDS). MDS Nurse #1 was re-educated by the Administrator regarding the process for identifying those residents that have the potential for communication deficits related to preferred language, updating the plan of care and accurately coding the	

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F 641

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also ask them to help translate conversations. Nurse #1 added as a last resort she would contact the resident ' s family for translation.

An interview on 3/15/18 at 8:53 am with Nursing Assistant (NA) #1 revealed Resident #112 could only speak a few words in English. She stated the resident could use body language to communicate some of her needs, but if she couldn ' t understand what Resident #112 needed she would go and get one of the employees that spoke Spanish to translate for her.

An interview on 3/15/18 at 10:28 pm with MDS Nurse #1 revealed she had completed the MDS dated 2/21/18 for Resident #112. She stated the resident was more Spanish speaking than English speaking and they did use a couple of Spanish speaking employees to translate and communicate with the resident. MDS Nurse #1 added she had made an error in coding the language section of the MDS and she would need to complete a correction to the assessment.

An interview on 3/15/18 at 5:32 pm with the Administrator revealed it was her expectation that the MDS assessment be coded accurately and reflect the resident ' s condition.

F 641

language section of the minimum data set (MDS)

IDENTIFICATION OF OTHERS

Starting April 4, 2018 April 6, 2018 the Director of Nursing and MDS Coordinators completed an audit of 100% of residents currently in the facility and no other non-English speaking were identified.

SYSTEMIC CHANGES

The Director of Nursing Services and MDS coordinators will review all new admissions to identify for the potential for communication deficits in the daily clinical stand up meeting, Monday Friday and document the findings on the daily clinical stand up form. Care plan will be updated during the daily clinical stand up meeting and documented on the daily clinical stand up form.

MONITORING PROCESS

Effective April 6, 2018 The Director of Nursing and MDS Case managers will monitor compliance by reviewing all new admissions to identify those residents whose preferred language is not English and update the care plan in the daily clinical stand up meeting Monday Friday for 2 weeks, then weekly for 2 weeks, then monthly for 3 months or until a pattern of compliance is maintained. Effective April 6, 2018, the Director of Nursing Services will report the finding to

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F 641	Continued From page 10	F 641	the Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure a facility remains in substantial compliance. RESPONSIBLE PARTY Effective 4/6/2018 the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights	F 656		4/27/18

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F 656	Continued From page 11 under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed develop a resident centered care plan that identified the primary language for Resident #112 was Spanish. This was evident for 1 of 1 resident that was reviewed for communication. Findings Included: Resident #112 was admitted to the facility on 2/7/18 and diagnoses included osteomyelitis, cellulitus of left lower limb, non-pressure chronic foot ulcer, diabetes, and depressive disorder. An admission minimum data set (MDS) dated	F 656	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. F656D Develop/Implement	

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2/7/18 for Resident #112 revealed she did not need or want an interpreter, her preferred language was blank and her brief interview for mental status (BIMS) was 13.

The care plan dated 2/16/18 for Resident #112 did not identify that the resident had the potential for communication deficits related to her preferred language being Spanish.

An interview was attempted with Resident #112 on 3/13/18 at 2:00 pm. The resident was able to say simple phrases such as "Hello" and "Thank You" in English, but primarily spoke Spanish. She was unable to carry on a conversation or answer questions that were asked in English.

An interview on 3/14/18 at 2:11 pm with Nurse #1 revealed Resident #112 primarily spoke Spanish but did speak a few English words. She stated Resident #112 was able to communicate most of the time with gestures and Nurse #1 would use her cell phone application to translate the conversation. Nurse #1 added there were several employees that spoke Spanish and she would also ask them to help translate conversations. Nurse #1 added as a last resort she would contact the resident ' s family for translation.

An interview on 3/15/18 at 8:53 am with Nursing Assistant (NA) #1 revealed Resident #112 could only speak a few words in English. She stated the resident could use body language to communicate some of her needs, but if she couldn ' t understand what Resident #112 needed she would go and get one of the employees that spoke Spanish to translate for her.

An interview on 3/15/18 at 10:28 am with MDS

F 656

Comprehensive Care Plan

ROOT CAUSE

The alleged noncompliance resulted from MDS Nurse #2 failed to develop a resident centered comprehensive care plan that identified the primary language for Resident #112 as Spanish.

IMMEDIATE ACTION

On March 15, 2018 the MDS Nurse #2 made a correction to Resident #112 comprehensive care plan to include a Spanish speaking communication plan. MDS Nurse #1 was reeducated regarding the process for identifying those residents that have the potential for communication deficits related to preferred language and updating the plan of care.

IDENTIFICATION OF OTHERS

On 3/15/2018 the Director of Nursing and MDS completed an audit of 100% of residents currently in the facility and no other non-English speaking were identified.

SYSTEMIC CHANGES

Starting April 4, 2018 April 6, 2018 The Director of Nursing Services re-educated all MDS coordinators on the process of reviewing new admissions to identify those residents that have for the potential for communication deficits. The Director of Nursing Services and MDS

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Nurse #2 revealed she had completed the care plan dated 2/16/18 for Resident #112. She added it was an error on her part and she should have developed a communication care plan for Resident #112.

An interview on 3/15/18 at 5:32 pm with the Administrator revealed it was her expectation that a resident ' s care plan would include all of their needs, including communication needs.

coordinators will review all new admissions in the daily clinical stand up meeting Monday Friday and update the care plan at time. Finding of the this review will be documented on the clinical stand up form and maintained in the clinical stand up binder.

MONITORING PROCESS

Effective April 6, 2018 The Director of Nursing and MDS coordinators will monitor compliance by reviewing all new admissions to identify those residents whose preferred language is not English in the daily clinical stand up meeting Monday Friday for 2 weeks, then weekly for 2 weeks, then monthly for 3 months or until a pattern of compliance is maintained.
Effective April 6, 2018, the Director of Nursing Services will report the finding to the Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure a facility remains in substantial compliance.

RESPONSIBLE PARTY

Effective 4/6/2018 the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.

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F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to update the care plan to reflect a 30 day significant weight loss for 1 of 4 residents that were reviewed for nutrition (Resident #47) and failed to invite an alert and oriented resident to participate in review of their care plan (Resident #56.)	F 657	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan	4/27/18

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Findings Included:

1. Resident #47 was admitted to the facility on 11/6/17 and diagnoses included dementia, failure to thrive and cognitive communication deficit.

A care plan dated 11/20/17 for Resident #47 stated resident was at risk for nutritional decline related to dementia, cognitive communication deficit, history of falls, adult failure to thrive, hypertension and pneumonia. Resident required a mechanically altered diet and assistance with eating. Oral intake varied from 25% to 100%. Interventions include to provide diet as ordered, determine food preferences, honor choices as able, offer alternative meal if resident refused main meal and provide supplementation for added nutrition support.

A quarterly minimum data set (MDS) dated 1/9/18 for Resident #47 identified her weight as 126 pounds (lbs.), she had not experienced any significant weight loss or gain, received a mechanically altered diet, required extensive assistance with eating and had severely impaired cognition.

Review of the weight record for Resident #47 identified her weight was 136 lbs. on 11/6/18 and was 126.6 lbs. on 12/4/18. This reflected a 6.9% weight loss in 30 days.

An interview on 3/15/18 at 10:14 am with Dietary Manger #2 revealed she was responsible for updating residents care plans with significant weight changes. She stated she should have updated Resident #47 ' s care plan to reflect the 6.9% weight loss that occurred in December 2017.

F 657

of correction is prepared and submitted solely because of the requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident.

F657 Care Plan Timing and Revision

ROOT CAUSE

The alleged noncompliance resulted from the facilities Dietary Manager failed to update the care plan of 1 resident #47 to reflect a 30-day significant weight loss and the facilities Social Service Director failed to invite 1 resident #56 to his care plan meeting and not maintain a record of the care plan attendance.

IMMEDIATE ACTION

0n March 15, 2018 the Dietary Manager updated resident #47 care plan to reflect a 30-day significant weight loss. On March 15, 2018 the Dietary Manager was re-educated by the Administrator regarding the process for updating the resident care plan when a significant weight loss is identified. On March 15, The Social Service Director was re-educated by the Administrator regarding the process of providing invitations to care plan meetings and maintain documentation of those invitations. On March 21,2018 the Director of Social Services held and documented a care plan meeting with resident #47.

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An interview with MDS Nurse #2 on 3/15/18 at 10:20 am revealed that residents who had significant weight loss should have an update made to their care plan to reflect their current nutritional status.

2. Resident #56 was admitted to the facility on 9/4/17 and his diagnoses included cerebral vascular accident and diabetes.

A review of a quarterly minimum data set (MDS) dated 3/13/18 for Resident #56 revealed he had a brief interview mental score (BIMS) of 15.

During an interview with resident #56 on 3/13/18 at 11:35 am he revealed he had never been invited to a care plan meeting or been updated on his plan of care at the facility.

During an interview with the Social Worker (SW) on 3/15/18 at 10:35 am she revealed she was responsible for inviting residents and their families to their care plan meetings. The SW explained she mailed letters out to the families based on the care plan schedule. She stated she would need to check how the residents were invited as she had only worked at the facility for 3 months.

A follow-up interview with the SW on 3/15/18 at 11:13 am revealed residents were supposed to receive a copy of the care plan invitation letter. She stated she did not know if Resident #56 had ever been invited to his care plan and the facility did not keep any written records that the resident had been invited.

An interview on 3/15/18 at 7:36 pm with the

F 657

IDENTIFICATION OF OTHERS

On April 4, 2018 the Dietary Manager audited all residents that have a had a significant weight loss and reviewed their care plan to ensure it reflected a plan for the significant weight loss. No other residents were identified. On April 4, 2018 The Social Service Director audited all resident□s medical records to ensure that all residents had care plan meeting and no other resident were identified.

SYSTEMIC CHANGES

Effective April 6, 2018 The Dietary Manager will review identified resident with significant weight loss at the daily clinical stand up meeting and update the resident care plan. This will be documented on the clinical standup form and kept in the Director of Nurses Clinical Binder. Effective April 6, 2018 The Social Service Director will maintain a documented record of all resident□s invitations to the care plan meetings and will be reviewed at clinical stand up meeting Monday through Friday. This will be documented in Care Plan Binder and will be maintained in the Social Service office.

MONITORING PROCESS

Effective April 6, 2018 The Director of Nursing and the Dietary Manager will monitor compliance of identified significant weight loss and care plan updates in the daily clinical stand up

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F 657	Continued From page 17 Administrator revealed it was her expectation that residents who were alert and oriented be invited to their care plan meetings.	F 657	meeting Monday Friday for 2 weeks, then weekly for 2 weeks, then monthly for 3 months or until a pattern of compliance is maintained. Effective April 6, 2018 The Director of Nursing and Director of Social Services will monitor compliance by reviewing the record of care plan invitations in the daily clinical stand up meeting and Monday Friday for 2 weeks, then weekly for 2 weeks, then monthly for 3 months or until a pattern of compliance is maintained. Effective April 6, 2018, the Director of Nursing Services will report the finding to the Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure a facility remains in substantial compliance. RESPONSIBLE PARTY Effective 4/6/2018 the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in	F 809		4/27/18

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F 809	Continued From page 18 the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and resident interviews the facility failed to offer or deliver bedtime snacks to 1 of 1 resident (Resident #373). Finding included: During an interview with Resident #373 on March 14, 2018 at 7:57 pm she revealed the food was cold but staff reheated for her. Resident #373 also indicated that bedtime snacks were never passed out or offered to her. During an observation on Wednesday March 14, 2018 from 8pm until 9pm, no one was observed passing out or offering snacks to the residents that resided on the 500 hall. During a second interview with Resident #373 on March 14, 2018 at 9:05pm, she revealed that snacks were not offered or passed out during the	F 809	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. F809E Frequency of Meals/Snacks at Bedtime ROOT CAUSE The alleged noncompliance resulted from facilities failure to offer or deliver bedtime	

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night. Resident #373 indicated no one came by her room tonight (March 14, 2018).

An observation of Resident #373's room on March 14, 2018 at 9:05 pm revealed no snack had been left in her room.

During an interview with Nurse #52 on March 14, 2018 at 9:10pm revealed that snacks were passed out between 8pm and 9pm. Nurse #52 revealed she was not aware of who had passed snacks out on the 500 hall tonight.

During an interview with Dietary Manager on March 15, 2018 at 9:30 am, he revealed that snack were prepared daily for all residents in the facility and the nursing assistants (NAs) on the halls were responsible for passing out the snacks between 8pm and 9pm.

During an interview with the Administrator on March 15, 2018 at 9:40am she indicated that her expectation was all residents be offered a bedtime snack every night.

F 809

snacks to 1 resident # 373 on March 14th 2018.

IMMEDIATE ACTION

On March 15, 2018 the Director of Nursing Services and Unit Coordinators ensured all resident were offered and provided a bedtime snack. The Administrator met with the Dietary Manager to ensure the process of preparing and delivering bedtime snacks to the nursing units on daily basis was occurring and verified compliance.

IDENTIFICATION OF OTHERS

Starting April 4, 2018 April 6, 2018 all residents with a BIMS score of 8 or above were interviewed to verify that they were being offered and provided bedtime snacks. No other residents were identified.

SYSTEMIC CHANGES

Starting April 4, 2018 - April 6,2018 The Director of Nursing and Staff Develop Coordinator will complete 100% education for all Dietary, Licensed nurses and certified nursing assistants. The education will include that the Dietary Department will prepare bedtime snacks for all residents and deliver them to the nursing units daily and will notify CNA staff when this is completed. The Certified Nursing Assistants will offer and provide bedtime snacks to all residents and document this in the smart charting. This education will

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F 809	Continued From page 20	F 809	be completed by April 6, 2018. Any Dietary staff, licensed nurses and certified nursing assistants not educated prior to April 6, 2018 will not be allowed to work until educated. MONITORING PROCESS Effective 4/6/2018 The Director of Nursing, Staff Develop Coordinator and or Unit Coordinators will monitor compliance by reviewing the CNA smart charting documentation of offering and providing bedtime snacks and review daily at clinical stand up, Monday Friday for 2 weeks, then weekly for 2 weeks, then monthly for 3 months or until a pattern of compliance is maintained. Effective April 4, 2018, the Director of Nursing Services will report the finding to the Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure a facility remains in substantial compliance. RESPONSIBLE PARTY Effective 4/6/2018 the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	