STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345236	A. BUILDING _____ B. WING _____	C 06/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WILMINGTON	820 WELLINGTON AVENUE WILMINGTON, NC 28401

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F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to accurately code rejection of care on a minimum data set (MDS) for 1 of 23 sampled residents whose MDS assessment were reviewed. Findings included: Record review revealed Resident #22 was admitted to the facility on 10/24/17. The resident's documented diagnoses included dorsalgia (upper back pain), hypertension, diabetes, and chronic pain syndrome. Review of the resident's electronic progress notes revealed it was documented he refused wraps to his bilateral lower extremities four times between 04/04/18 and 04/09/18, refused insulin six times between 04/04/18 and 04/09/18, refused Senna (medication used to treat constipation) three times between 04/04/18 and 04/09/18, and refused to have his monthly weight taken on 04/04/18. The resident's 04/10/18 quarterly MDS documented his cognition was intact, he exhibited no delirium/mood issues/psychosis/behaviors/wandering, he did not reject care, and he required extensive assistance from staff to being dependent of staff for his activities of daily living (ADLs). At 9:42 AM on 06/15/18 the Director of Nursing (DON) stated the facility had a lot of problems	F 641	F 641 Accuracy of Assessments 1. Process that lead to the deficiency: The alleged noncompliance resulted from a minimum data set dated 04/10/18 that did not identify that resident #22 was rejecting care. The facility failed to accurately code the minimum data set to reflect the above. 2. Correction for specific deficiency cited: On 06/15/18, resident #22 was accurately reassessed and the Minimum data set dated 06/21/18 was modified to indicate rejection of care in section E. The current MDS coordinator was educated by the regional nurse consultant on 06/15/18 regarding the process for identifying those residents that reject care and accurately coding the minimum data sets. 3. The monitoring processes and systemic changes to ensure plan of correction is effective: Starting 06/15/18 the MDS Coordinator and Director of Nursing services completed an audit on residents currently in the facility to determine if any other residents were rejecting care. Based on the audit of current residents section E of the minimum data set shows no further	6/21/18

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

Electronically Signed | 06/29/2018

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F 641	Continued From page 1 with Resident #22 rejecting care which included refusal to take medications, refusal to allow staff to provide care, and refusal to have labs drawn. He reported it was his expectation that if these behaviors were exhibited during the 7-day look back period that they be coded under the section of the MDS assessments which addressed rejection of care. At 10:22 AM on 06/15/18 a MDS Nurse (Nurse #6) stated Social Services completed the MDS sections dealing with behaviors including rejection of care. However, she reported that the Social Worker who completed the behavior section of Resident #22's 04/10/18 quarterly MDS assessment no longer worked in the facility. She commented Social Services should be reviewing staff and physician progress notes when completing the behavior sections of the MDS assessments. After reviewing progress notes for Resident #22 between 04/04/18 and 04/09/18, she stated it should have been documented that the resident rejected care on his 04/10/18 MDS assessment.	F 641	inaccurate coding The MDS coordinator will review daily nursing notes to identify any residents that are rejecting care during an assessment period to accurately code the minimum data set. Effective 06/18/18, the Director of Nursing and the MDS coordinator will monitor compliance by reviewing daily nursing notes to identify those residents that are rejecting care and to ensure the rejection of care is accurately coded on the minimum data set. This process will occur Monday thru Friday for 2 weeks, then weekly for 2 weeks, then monthly for 3 months or until a pattern of compliance is maintained. Effective 06/20/18, the MDS coordinator will report the findings 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 Quality Assurance and Performance Improvement committee can modify this plan to ensure a facility remains in substantial compliance. 4. Responsible Party: Effective 06/20/18, the Administrator and MDS coordinator are responsible to ensure implementation of this plan of correction for this alleged noncompliance and to ensure the facility remains in substantial compliance.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		6/20/18

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F 656	Continued From page 2 §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 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	F 656		

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F 656	Continued From page 3 requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to develop a care plan to address the problem of rejection of care which had the potential to affect the health and welfare of 1 of 23 sampled residents whose minimum data set (MDS) assessments were reviewed. Findings included: Record review revealed Resident #22 was admitted to the facility on 10/24/17. The resident's documented diagnoses included dorsalgia (upper back pain), hypertension, diabetes, and chronic pain syndrome. The resident's 04/10/18 quarterly MDS documented his cognition was intact, he exhibited no delirium/mood issues/psychosis/behaviors/wandering, he did not reject care, and he required extensive assistance from staff to being dependent of staff for his activities of daily living (ADLs). At 9:42 AM on 06/15/18 the Director of Nursing (DON) stated the facility had a lot of problems with Resident #22 rejecting care which included refusal to take medications, refusal to allow staff to provide care, and refusal to have labs drawn. He reported that these refusals had the potential to affect the resident's health and welfare in the facility. He commented he would expect the facility to have a care plan which documented interventions that would enable staff to get more cooperation from the resident. At 10:22 AM on 06/15/18 a MDS Nurse (Nurse	F 656	F 656 Develop/Implement Comprehensive Care Plans 1. Process that lead to the deficiency: The alleged noncompliance occurred when the facility failed to develop a care plan to address the problem of rejection of care which has the potential to affect the health and welfare of resident #22. 2. Correction for specific deficiency cited: On 06/15/18, the MDS coordinator revised the care plan for resident #22 to reflect rejection of care. On 06/15/18, the regional nurse consultant re-educated the MDS coordinators on comprehensive care plans. 3. The monitoring processes and systemic changes to ensure plan of correction is effective: On 06/15/18 the Director of Nursing and MDS coordinator completed an audit of residents currently in the facility. The audit tool was to identify residents that reject care as noted in nursing notes and staff interviews. Care plans were reviewed, but no revisions were required. On 06/15/18, the regional nurse consultant re-educated the current MDS coordinators on the requirements for developing a care plan and a process of reviewing nursing notes daily, Monday thru Friday, to identify residents that reject care and that the current care plan is	

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F 656	Continued From page 4 #6) stated Social Services completed the MDS sections dealing with behaviors including rejection of care. However, she reported that the Social Worker who completed the behavior section of Resident #22's 04/10/18 quarterly MDS assessment no longer worked in the facility. She commented Social Services should be reviewing staff and physician progress notes when completing the behavior sections of the MDS assessments. After reviewing progress notes for Resident #22 between 04/04/18 and 04/09/18, she stated it should have been documented that the resident rejected care on his 04/10/18 MDS assessment. According to Nurse #6, this rejection of care was an ongoing problem with Resident #22, and it would be helpful to develop a care plan that would require an inter-disciplinary approach for developing techniques that might improve the resident's desire to cooperate with staff.	F 656	reflective of the residents current status. The MDS coordinator will monitor the compliance of developing care plans on residents that reject care, monthly times 3 months or until a pattern of compliance is maintained. Effective 06/20/18 the MDS Coordinator and director of nursing will report the findings of the audits and observations to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months or until a pattern of sustainable compliance is maintained. The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remains in substantial compliance. 4. Responsible Party: Effective 06/20/18 the MDS coordinator and Director of Nursing services are responsible to ensure implementation of this plan of correction for this alleged noncompliance and to ensure the facility remains in substantial compliance.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, physician	F 677	F 677 ADL Care Provided for Dependent	6/20/18

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F 677	Continued From page 5 interview and record review the facility failed to provide care for 1 of 4 sampled residents who did not receive adequate activity of daily living (ADL) care resulting in moisture associated skin damage (MASD), Resident #73. Findings included: Record review revealed that resident #73 was admitted to the facility on 05/20/15 with diagnoses that included chronic respiratory failure, intracerebral hemorrhage, hemiplegia, Type 2 diabetes mellitus, and persistent vegetative state. Physician orders included an indwelling foley catheter started on 01/19/18 for a diagnosis of moisture associated skin damage along with Endit cream to buttocks every shift and as needed. Review of the plan of care for Resident #73 dated 06/10/18 included goals and interventions for incontinence care documenting that the resident was dependent on staff for all incontinence care. Review of the annual Minimum Data Set (MDS) assessment dated 05/29/18 documented that Resident #73 did not respond and was total care for all ADL's. An interview was conducted with the Director of Nursing on 06/12/18 at 4:50 PM. He stated that Resident #73 had an indwelling foley catheter because of MASD. He said that the Wound Care Specialist Physician had ordered the catheter. An interview was conducted with the Wound Care Specialist Physician on 06/13/18 at 10:05 AM. He stated that the reason he requested that the resident have an indwelling foley catheter placed was because every week when he came to the facility to treat the resident for MASD he found the resident wet with urine. He said it was also	F 677	Residents 1. Process that lead to the deficiency: The alleged noncompliance resulted when the facility failed to provide adequate incontinent care resulting in moisture associated skin damage for resident #73. 2. Correction for specific deficiency cited: On 6/14/2018 the Foley catheter for resident #73 was discontinued and incontinent care is performed routinely. Resident #73 moisture associated skin damage continues to improve week over week. The wound care nurse or the assistant director of nursing validates that incontinent care is given timely and that moisture associated skin damage is improving. Starting on 06/13/18, the staff development coordinator re-educated current certified nursing assistants on the importance of providing timely incontinent care for dependent residents. 3. The monitoring processes and systemic changes to ensure plan of correction is effective: Starting 06/15/18 the wound care nurse and Director of Nursing services or Assistant director of nursing completed an audit on dependent incontinent residents currently in the facility to determine if any other residents had moisture associated skin damage. Based on the audit of current residents, there were no other residents found to have moisture associated skin damage.	

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F 677	Continued From page 6 common for the resident to have frequent loose stools because he was on a tube feeding. He reported that the resident's wounds on his buttocks were caused by moisture. He said the resident did not have a pressure ulcer, urine retention or a neuorgenic bladder and could void on his own without the aide of a urinary catheter. He stated he would consider discontinuing the catheter because he felt patient care had improved since the facility had recently changed owners and that there was a new spirit in the building. An observation of wound care for Resident #73 was made on 06/13/18 at 11:45 AM. Care was provided by the Wound Care Specialist Physician and the facility wound care nurse. There were no dressing on the areas of MASD as the wounds were being treated with Endit cream. The wounds were measured by the physician: 1. Right lateral buttock MASD = 4.5 cm x 3 cm, 2. Right upper medial buttock MASD = 1.5 cm x 2.6 cm, and 3. Left upper medial buttock MASD = 1.7 cm x 1.2 cm. There was no measurable depth for any of the wounds. The physician commented that the wounds had improved over the previous week. An observation of Resident #73 was made on 06/14/18 at 1:00 PM. The resident's foley catheter had been removed after the Wound Care Specialist Physician met with the family, Social Worker, Administrator and Director of Nursing. An observation of incontinence care was made on 06/14/18 at 3:40 PM for Resident #73. Care was provided by Nursing Assistants #6 and #7. The tube feeding had been turned off 10 minutes	F 677	Effective 06/18/18, the Director of Nursing or assistant director of nursing and the wound care nurse will monitor compliance by observing 5 incontinent residents weekly to validate timely incontinent care and that there is no moisture associated skin damage. This process will occur Monday thru Friday for 2 weeks, then weekly for 2 weeks, then monthly for 3 months or until a pattern of compliance is maintained. Effective 06/20/18, the Director of nursing will report the findings 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 Quality Assurance and Performance Improvement committee can modify this plan to ensure a facility remains in substantial compliance. 4. Responsible Party: Effective 06/20/18, the Administrator and Director of nursing are responsible to ensure implementation of this plan of correction for this alleged noncompliance and to ensure the facility remains in substantial compliance.	

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F 677	Continued From page 7	F 677		

prior to care as ordered. The soiled diaper removed from the resident was mostly dry with one quarter sized area of wetness noted. It was discarded appropriately. Incontinence care was delivered using proper technique. Standard precautions were followed and proper handwashing was observed. Endit cream was applied to the resident's buttocks as ordered. The resident did not respond during care.

An interview was conducted with Nursing Assistant #5 on 06/15/18 at 9:45 AM. She stated that she had worked at the facility for nine years. She said that she usually worked on the 600 hall but floated to other areas as needed. She said that incontinence rounds were completed every 2 hours. She said that before the new company took over she had assignments that included 20 residents and it was hard to complete her work. Today she reported that she had 10 residents on her assignment and had time to provide better care. She said the new owners were "hands on" and involved in the care provided to residents. She stated that there were now more staff in the building and that everyone had received a raise in pay. She commented that she was trying to get other aides to come to work at the facility because the environment was so nice now.

An interview was conducted with the SDC Nurse on 06/15/18 at 11:15 AM. She stated that she had noticed an improvement at the facility since the turn over. She said the new owners were very attentive. She reported that meetings were held with staff twice a month to get suggestions and determine needs. She said staff moral was much improved because of the pay raise and the decrease in the amount of residents on each assignment. She commented that she had

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F 677	Continued From page 8 oriented 29 newly hired staff since May 1, 2018. An interview was conducted with the Director of Nursing on 06/15/18 at 12:05 PM. He stated that he expected rounds to be completed for all residents every two hours to include incontinence care and positioning. He reported that the facility had started a new plan on 06/11/18 to make a friendly overhead announcement every two hours that would prompt staff to make rounds. He said it was also intended to prompt the unit coordinators to make rounds to insure residents were being repositioned every two hours. The announcements were also strategically geared toward engaging residents in activities being offered. He said staff were being in-serviced beginning 06/11/18 and he hoped everyone would be on board with the new plan by the end of the week.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review the facility failed to provide care to prevent moisture associated skin damage (MASD) for 1 of 1 residents (#73).	F 684	F 684 Quality of Care 1. Process that lead to the deficiency: The alleged noncompliance resulted when the facility failed to provide adequate incontinent care resulting in moisture	6/20/18

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F 684	Continued From page 9 Findings included: Record review revealed that resident #73 was admitted to the facility on 05/20/15 with diagnoses that included chronic respiratory failure, intracerebral hemorrhage, hemiplegia, Type 2 diabetes mellitus, and persistent vegetative state. Physician orders included an indwelling foley catheter started on 01/19/18 for a diagnosis of moisture associated skin damage along with Endit cream to buttocks every shift and as needed. Review of the plan of care for Resident #73 dated 06/10/18 included goals and interventions for incontinence care documenting that the resident was dependent on staff for all incontinence care. Review of the annual Minimum Data Set (MDS) assessment dated 05/29/18 documented that Resident #73 did not respond and was total care for all ADL's. An interview was conducted with the Director of Nursing on 06/12/18 at 4:50 PM. He stated that Resident #73 had an indwelling foley catheter because of MASD. He said that the Wound Care Specialist Physician had ordered the catheter. An interview was conducted with the Wound Care Specialist Physician on 06/13/18 at 10:05 AM. He stated that the reason he requested that the resident have an indwelling foley catheter placed was because every week when he came to the facility to treat the resident for MASD he found the resident wet with urine. He said it was also common for the resident to have frequent loose stools because he was on a tube feeding. He reported that the resident's wounds on his buttocks were caused by moisture. He said the resident did not have a pressure ulcer, urine retention or a neuorgenic bladder and could void	F 684	associated skin damage for resident #73. 2. Correction for specific deficiency cited: On 6/14/2018 the Foley catheter for resident #73, was discontinued and incontinent care is performed routinely. Resident #73 moisture associated skin damage continues to improve week over week. The wound care nurse or the assistant director of nursing validates that incontinent care is given timely and that moisture associated skin damage is improving Starting on 06/13/18, the staff development coordinator re-educated all current certified nursing assistants on the importance of providing timely incontinent care for dependent residents. The monitoring processes and systemic changes to ensure plan of correction is effective: Starting 06/15/18 the wound care nurse and Director of Nursing services or Assistant director of nursing completed an audit on dependent incontinent residents currently in the facility to determine if any other residents had moisture associated skin damage. Based on the audit of current residents there were no other residents found to have moisture associated skin damage. Effective 06/18/18, the Director of Nursing or assistant director of nursing and the wound care nurse will monitor compliance by observing 5 incontinent residents weekly to validate timely incontinent care	

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F 684	Continued From page 10 on his own without the aide of a urinary catheter. He stated he would consider discontinuing the catheter because he felt patient care had improved since the facility had recently changed owners and that there was a new spirit in the building. An observation of wound care for Resident #73 was made on 06/13/18 at 11:45 AM. Care was provided by the Wound Care Specialist Physician and the facility wound care nurse. There were no dressing on the areas of MASD as the wounds were being treated with Endit cream. The wounds were measured by the physician: 1. Right lateral buttock MASD = 4.5 cm x 3 cm, 2. Right upper medial buttock MASD = 1.5 cm x 2.6 cm, and 3. Left upper medial buttock MASD = 1.7 cm x 1.2 cm. There was no measurable depth for any of the wounds. The physician commented that the wounds had improved over the previous week. An observation of Resident #73 was made on 06/14/18 at 1:00 PM. The resident was in a vegetative state and did not respond to verbal stimulation. He did not appear sweaty and had very limited movements. The resident's foley catheter had been removed after the Wound Care Specialist Physician met with the family, Social Worker, Administrator and Director of Nursing. An observation of incontinence care was made on 06/14/18 at 3:40 PM for Resident #73. Care was provided by Nursing Assistants #6 and #7. The tube feeding had been turned off 10 minutes prior to care as ordered. The soiled diaper removed from the resident was mostly dry with one quarter sized area of wetness noted. It was	F 684	and that there is no moisture associated skin damage. This process will occur Monday thru Friday for 2 weeks, then weekly for 2 weeks, then monthly for 3 months or until a pattern of compliance is maintained. Effective 06/20/18, the Director of nursing will report the findings 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 Quality Assurance and Performance Improvement committee can modify this plan to ensure a facility remains in substantial compliance. 3. Responsible Party: Effective 06/20/18, the Administrator and Director of nursing are responsible to ensure implementation of this plan of correction for this alleged noncompliance and to ensure the facility remains in substantial compliance.	

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discarded appropriately. Incontinence care was delivered using proper technique. Standard precautions were followed and proper handwashing was observed. Endit cream was applied to the resident's buttocks as ordered. The resident did not respond during care.

An interview was conducted with Nursing Assistant #5 on 06/15/18 at 9:45 AM. She stated that she had worked at the facility for nine years. She said that she usually worked on the 600 hall but floated to other areas as needed. She said that incontinence rounds were completed every 2 hours. She said that before the new company took over she had assignments that included 20 residents and it was hard to complete her work. Today she reported that she had 10 residents on her assignment and had time to provide better care. She said the new owners were "hands on" and involved in the care provided to residents. She stated that there were now more staff in the building and that everyone had received a raise in pay. She commented that she was trying to get other aides to come to work at the facility because the environment was so nice now.

An interview was conducted with the SDC Nurse on 06/15/18 at 11:15 AM. She stated that she had noticed an improvement at the facility since the turn over. She said the new owners were very attentive. She reported that meetings were held with staff twice a month to get suggestions and determine needs. She said staff moral was much improved because of the pay raise and the decrease in the amount of residents on each assignment. She commented that she had oriented 29 newly hired staff since May 1, 2018.

An interview was conducted with the Director of

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F 684	Continued From page 12 Nursing on 06/15/18 at 12:05 PM. He stated that he expected rounds to be completed for all residents every two hours to include incontinence care and positioning. He reported that the facility had started a new plan on 06/11/18 to make a friendly overhead announcement every two hours that would prompt staff to make rounds. He said it was also intended to prompt the unit coordinators to make rounds to insure residents were being repositioned every two hours. The announcements were also strategically geared toward engaging residents in activities being offered. He said staff were being in-serviced beginning 06/11/18 and he hoped everyone would be on board with the new plan by the end of the week.	F 684		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §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	F 690		6/20/18

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F 690	Continued From page 13 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 observation, staff interviews, and record review the facility failed to: 1) provide adequate catheter care for 1 of 2 residents (#73) whose catheter was improperly positioned above the level of the bladder; 2) administer medications as ordered to treat urinary tract infections for 2 of 3 residents (#73 and #20); and 3) collect urine in a time frame which met facility expectations causing a delay in the treatment of a urinary tract infection for 1 of 3 residents (#22). Findings included: 1. Record review revealed that resident #73 was admitted to the facility on 05/20/15 with diagnoses that included chronic respiratory failure, intracerebral hemorrhage, hemiplegia, Type 2 diabetes mellitus, and persistent vegetative state. Physician orders included an indwelling foley catheter started on 01/19/18 for a diagnosis of moisture associated skin damage. Review of the plan of care for Resident #73 dated 06/10/18	F 690	F 690 Bowel Bladder Incontinence, Catheter, UTI 1. Process that lead to the deficiency: The alleged noncompliance resulted when the certified nursing assistant failed to provide adequate catheter care for resident #73, when the catheter was improperly positioned above the level of the bladder; when the licensed nurses failed to administrator medications as ordered to treat urinary tract infections for residents #73 and resident #20; and when the licensed nurses failed to collect a urine specimen for resident #22 in an adequate time frame causing a delay in the treatment of an urinary tract infection. 2. Correction for specific deficiency cited: On 6/13/18 at 11:15 AM resident #73 catheter bag was positioned below the level of the bladder by the Director of Nursing. Certified nursing assistants that	

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F 690	Continued From page 14 showed that it included foley catheter care. Review of the annual Minimum Data Set (MDS) assessment dated 05/29/18 revealed that Resident #73 was coded for an indwelling catheter. Review of the facility policy for Urinary Catheter Care (Revised September 2014) read: 1. Check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheter and tubing free of kinks. 2. Unless specifically ordered, do not apply a clamp to the catheter. 3. The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. During an observation made on 06/13/18 at 11:15 AM of Resident #73 the foley catheter bag was not visible. The Director of Nursing came into the resident's room and found the catheter bag under the resident midway up his back above the level of the bladder. The bag was half full of urine. The resident's skin was observed to be intact with normal color and an indentation from the bag. The Director of Nursing repositioned the catheter bag to the bed frame below the level of the bladder. An interview was conducted with the Director of Nursing on 06/13/18 at 11:25 AM. He stated that he expected foley bags to always be positioned below the level of the bladder and secured properly on a bed frame. An interview was conducted with Nursing Assistants #8 and #9 on 06/13/18 at 2:40 PM. They revealed that they had worked together and had provided care to Resident #73 all day.	F 690	delivered the care to resident #73 were re-educated by the Director of Nursing on 6/13/18 on the proper positioning of a catheter bag. Resident #73 was assessed by MD on 6/12/18 and the antibiotic was discontinued. On 6/13/18 the MD was notified of two missed Cipro doses for resident #20 and the MD did not re order the medication. Resident #22 UA, C&S was obtained on 1/7/2018 and antibiotics started on 1/10/18 with no adverse outcomes. The Licensed nurses were re-educated to notify the MD when the resident refuses to allow an ordered UA to be collected and how to use the OMNICELL for back up medications. 3. The monitoring processes and systemic changes to ensure plan of correction is effective: Starting 06/13/18, the Staff development coordinator re-educated the current certified nursing assistants on urinary catheter care and proper placement of the Foley catheter bag. The staff development coordinator re-educated the current licensed nurses on notification of MD when a resident refuses to allow the collection of a UA. Licensed nurses were re-educated by the staff development coordinator on 06/15/18 on transcribing physician orders and implementing orders when received and	

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F 690	Continued From page 15 Nursing Assistant #8 stated that the care they provided to the resident included emptying the foley catheter bag and reporting the amount of urine discarded to the nurse. She said they normally moved the foley catheter bag from one side of the bed frame to the other when providing care. She reported that it was not a normal practice to lay the catheter bag on the resident's bed. Both Nursing Assistants stated that they were sorry that this had happened. They both said that they knew to keep a foley bag below the level of the bladder to prevent urine from draining back into the bladder and possibly causing an infection. 2. a. Record review revealed that Resident #73 was transported to the emergency room for evaluation on 06/10/18 after vomiting through his mouth and his tracheotomy. Review of the nursing progress note written by Nurse #2 dated 06/11/18 read: "returned from emergency room on 06/10/18 on 3-11 shift with a diagnosis of a UTI (urinary tract infection). First dose of ABT (antibiotic) given at ER." Review of the physician's order written by Physician #2 dated 06/10/18 was: Macrobid 100mg capsule-take one capsule two time daily; quantity 20. Review of the Medication Administration Record (MAR) for June 2018 revealed that that order for Macrobid 100mg had not been transcribed to the record and had not been administered at the facility. The resident missed two doses of the antibiotic on 06/11/18 and one dose on 06/12/18 prior to the discovery that it had not been transcribed onto the MAR.	F 690	the use function of the OMNICELL for back up medications. The Director of Nursing or Assistant Director of nursing will audit MD orders daily Monday thru Friday and the RN supervisor will audit MD orders on the weekend daily for 30 days and weekly for 2 months The staff development coordinator or Assistant Director of nursing will audit by observation residents with Foley catheters weekly for 12 weeks to ensure Foley catheter bags are below the bladder at all times. This process will occur for 3 months or until a pattern of compliance is maintained. Effective 06/20/18, the Director of nursing will report the findings 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 Quality Assurance and Performance Improvement committee can modify this plan to ensure a facility remains in substantial compliance. 4. Responsible Party: Effective 06/20/18, the Administrator and Director of Nursing are responsible to ensure implementation of this plan of correction for this alleged noncompliance and to ensure the facility remains in substantial compliance.	

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An interview was conducted with Nurse #2 on 06/12/18 at 3:40 PM. She stated that she had received Resident #73 back from the emergency room on 06/10/18 at 10:16 PM. She said that the first dose of the antibiotic had been given at the emergency room and that she immediately faxed the order for the Macrobid to the pharmacy to be filled. She stated that she should have entered the order into the MAR at that time but did not. She revealed that she would have caught the error the next day but that she was off and did not work. She agreed that the resident had missed three doses of the medication because the order had not been transcribed onto the MAR.

An interview was conducted with Physician #1 on 06/12/18 at 4:30 PM. He stated that he was not aware that Resident #73 had been ordered an antibiotic for a UTI because he was not on call over the weekend and had been on vacation Monday. He said that he had worked at the facility for 10 years and was very familiar with Resident #73. He reported that he had assessed the resident earlier in the day and he looked the same as always with no fever or other symptoms of a UTI. He said his plan was to discontinue the antibiotic and watch the resident for signs of infection. He stated that he felt the resident had no harm as a result of not receiving the medication after returning to the facility.

An interview was conducted with the Director of Nursing on 06/12/18 at 4:40 PM. He stated that he expected orders to be transcribed to the MAR correctly, double checked by third shift staff each night for accuracy and given as ordered.

2. b. Record review revealed Resident #20 was admitted to the facility 08/18/16 with a most

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recent re-admission on 04/02/18 with diagnoses that included quadriplegia, cerebral infarction, epilepsy, encephalopathy, and enterococcus sepsis. The plan of care dated 04/13/18 included bladder incontinence with interventions to observe and document symptoms of a UTI. The MDS assessment dated 04/09/18 was coded as always incontinent of bladder.

Review of the physician orders for Resident #20 revealed that she had been ordered Cipro 500 mg one tablet every 12 hours for UTI for 13 administrations with a start date of 05/26/18.

Review of the MAR for May and June of 2018 revealed that the resident only received 11 doses of the medication Cipro instead of 13 as ordered by the physician. The initial order had been rewritten twice and some doses were initialed twice for the same date and time because of the overlap when the order was rewritten. It was confirmed that no double doses were administered.

Review of the pharmacy Items Table List Report for the back up medication supply revealed that the medication Ciprofloxacin (Cipro) was available at the facility routinely for administration.

An interview was conducted with the Director of Nursing on 06/13/18 at 5:40 PM. He said that only 11 doses of Cipro could be accounted for as having been given to the resident. He said the facility had notified the physician of the medication error and had initiated an incident report. He revealed that he expected medications to be given as ordered. He said that the facility had a back up supply of Cipro on site and that it was available for administration.

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An interview was conducted with Medication Aide #8 on 06/14/18 at 11:09 AM. She stated that she remembered administering the medication Cipro to Resident #20. She said that she had given the initial dose that was obtained from the back up supply. She said that when she noticed that the order had been rewritten on the MAR with dates overlapping she initialed it twice to indicated that the medication had been given when originally initialed on the first writing of the order. She reported that she had not given any double doses of the medication to the resident on any date.

An interview was conducted with Medication Aide #10 on 06/14/18 at 5:25 PM. She stated that she remembered administering the medication Cipro to Resident #20 on 05/30/18 and 05/31/18 but did not remember administering the medication on 05/29/18. She stated that she did not remember why she did not administer the medication on 05/29/18 at 9:00 PM as ordered. Review of the MAR revealed that no explanation had been documented for the omission.

An additional interview was conducted with the Director of Nursing on 06/15/18 at 9:00 AM. He stated that if a medication were not available on the medication cart he expected the nurse or medication aide to obtain the medication from the back up supply. He further commented that if a medication were not available from the back up supply he would expect the nurse to notify the physician and obtain an order for a hold or an alternate. He stated that for the treatment of UTI's he expected orders to be obtained at the time of the diagnosis and initiated immediately since the medications were available on site.

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3. Record review revealed Resident #22 was admitted to the facility on 10/24/17. The resident's documented diagnoses included dorsalgia (upper back pain), hypertension, diabetes, and chronic pain syndrome.

Resident #22's 10/30/17 care plan identified, "(Resident) has a Foley catheter: neurogenic bladder" as a problem. Interventions to this problem included, "Observe/record/report to MD (physician) for s/sx (signs and symptoms) of UTI (urinary tract infection): pain, burning, blood tinged urine, cloudiness, no output, deeepening of urine color, increased pulse, increased temperature, frequent urination, and foul smelling urine."

A 01/02/18 2:06 PM Physician Note documented, "Pt c/o (patient complains of) burning and bladder spasms as well as foul smelling urine. Thinks that the Bactrim (antibiotic) he took a few weeks ago didn't work...."

A 01/02/18 physician order requested that an urinalysis (UA) and culture and sensitivity (C & S) be obtained for Resident #22.

A 01/03/18 12:11 PM Physician Note documented, "Pt states that his urine was not collected yesterday and that he is becoming nauseous. Also c/o lower (abdominal) pain...."

Documentation on the 01/03/18 24-hour report indicated that Resident #22 refused to have his urine collected.

A 01/04/18 2:15 PM Physician Note documented, "...c/o persistent nausea and abdominal pain x

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several days. Vomited x 1 yesterday. Reports this is typically what symptoms he has when he gets a UTI. Nurses still have not collected urine for a U/A--will also need C & S. Recently had UTI and was (treated) with Bactrim--pt reports it does not usually cover the UTI's he has. Unable to tolerate Macrobid, and has a PCN Ax (Penicillin allergy). Has used Cipro in past with relief. Reports he usually ends up needing a PICC line for (antibiotics). Has not had any fever, (vital signs) all stable. Urine has been dark. Denies (chest pain, shortness of breath), fever/chills."

A 01/05/18 1:53 PM progress note documented, "Pt still c/o (signs and symptoms of) UTI with (abdominal) pain, bladder spasms, and recently nausea. Per staff the pt has refused to let them change his catheter to get a clean specimen, but pt says that the staff has refused to do it. Discussed the situation with the pt. Told him that we couldn't give him any (antibiotic) til his urine was collected. He agreed to let staff change the catheter today and collect a new specimen." (Staff could not explain what happened to this urine sample).

A 01/06/18 10:37 PM progress note documented, "Resident coude catheter was changed per MD order without incident. Resident reports feeling markedly better, positive urine flow noted...clear yellow urine with no strong odor at this time...."

Lab results for Resident #22 documented urine was collected on 01/07/18, with C & S results available on 01/09/18. The results indicated there were greater than 100,000 colony forming units (CFU) of Proteus mirabilis (bacteria) present in the sample. On 01/09/18 a nurse handwrote on the results that the physician wanted the

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resident started on an antibiotic to be administered intramuscularly. Review of the resident's medication administration record (MAR) revealed the resident was started on his first dose of antibiotic on 01/10/18, eight days after an UA, C & S was ordered.

The resident's 04/10/18 quarterly minimum data set (MDS) documented he had no cognitive impairment, he exhibited no behaviors including rejection of care, he had an indwelling catheter, he required extensive assistance from a staff member with toileting, and he had no pressure ulcers.

At 9:42 AM on 06/15/18 the Director of Nursing (DON) stated his expectation was that staff collect the urine sample on the same day and shift that the UA was ordered by the physician, and if that could not be done, that the physician be notified so he or she could specify how to proceed. He reported the goal was to collect the urine as quick as possible so if residents were suffering from an UTI there signs and symptoms did not worsen and there discomfort did not increase until relief could be provided by an appropriate antibiotic.

At 4:05 PM on 06/15/18 Resident #22's primary physician stated the goal was to treat residents exhibiting multiple signs and symptoms of discomfort, affecting their quality of life, with an effective antibiotic as soon as possible if lab results identified large enough quantities of bacteria present in the urine, and the C & S specified those antibiotics capable of eradicating the bacteria. The physician commented if residents refused urine collection, staff should immediately contact the health provider who

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F 690	Continued From page 22 ordered the UA so that person could then make a decision about how to proceed with the resident's care. He stated he could not recall if he was the one who had ordered a UA, C & S for Resident #22 back in January 2018.	F 690		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to draw labs ordered by the physician to aide in determining treatment for self-reported symptoms indicative of an urinary tract infection (UTI) for 1 of 9 sampled residents whose lab results were reviewed. Findings included: Record review revealed Resident #22 was admitted to the facility on 10/24/17. The resident's documented diagnoses included dorsalgia (upper back pain), hypertension, diabetes, and chronic pain syndrome. A 01/02/18 2:06 PM Physician Note documented,	F 773	F 773 Lab Services Physician order/Notify of results 1. Process that lead to the deficiency: The alleged noncompliance resulted when the licensed nurses failed to collect a physician ordered basic metabolic panel and complete blood count on 1/12/2018 and 2/19/18 for resident #22, that would be used to aide in determining treatment. The licensed nurse did not notify the physician of the delay in obtaining the ordered labs. 2. Correction for specific deficiency cited: Resident #22 was treated by the physician	6/20/18

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F 773	Continued From page 23 "Pt c/o (patient complains of) burning and bladder spasms as well as foul smelling urine. Thinks that the Bactrim (antibiotic) he took a few weeks ago didn't work...." A 01/02/18 physician order requested that an urinalysis (UA) and culture and sensitivity (C & S) be obtained for Resident #22. A 01/03/18 12:11 PM Physician Note documented, "Pt states that his urine was not collected yesterday and that he is becoming nauseous. Also c/o lower (abdominal) pain...." A 01/10/18 9:57 AM Physician Note documented urine culture results were received with greater than 100,000 colony forming units (CFUs) of Proteus mirabilis (bacteria) found in the urine sample. A 01/12/18 physician order started Resident #22 on Gentamycin (antibiotic) 150 mg every 12 hours administered intramuscularly (IM) x 7 days with a basic metabolic panel (BMP) to be drawn immediately (STAT) on Monday morning, 01/15/18. Record review revealed there were no lab results available from a 01/15/18 blood draw. There was also no documentation in Resident #22's medical record that he refused to have the lab drawn. A 02/19/18 4:06 PM Physician Note documented, "Asked to see patient at his request as he thinks he has another UTI. Based on having chills, usually in evening and malodorous urine filled with sediment in foley tubing for last several days...."	F 773	for self-reported symptoms of a urinary tract infection and the symptoms resolved. MD was notified on 6/15/18 that the ordered labs on 1/12/18 and 2/19/18 were not obtained. 3. The monitoring processes and systemic changes to ensure plan of correction is effective: Director of nursing or assistant director of nursing completed an audit of MD orders for labs for the month of June on current residents. Labs ordered for June were obtained. Starting on 06/18/18 the Staff development coordinator will complete re-education with current licensed nursing staff. This education will include obtaining labs per MD orders and notification of MD when labs are not obtained. Licensed Nurses not re-educated prior to 06/30/18, will not be allowed to work until re-education has occurred. Effective 06/18/18, newly hired Licensed Nurses will receive education on obtaining labs per MD order and notification of MD when labs are not obtained. The Director of Nursing or Assistant Director of nursing will audit MD lab orders daily Monday thru Friday and the RN nursing supervisor will audit MD lab orders to ensure the labs were obtained or MD was notified. This process will occur for 3 months or until a pattern of compliance is maintained. Effective 06/20/18 the	

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F 773	Continued From page 24 A 02/19/18 physician order documented, "Change out Foley (catheter), then obtain sterile urine specimen for UA, C & S." The order also requested a complete blood count with differential (CBC with diff) and a BMP be collected the next morning. Record review revealed there were no lab results available from a 02/20/18 blood draw. There was also no documentation in Resident #22's medical record that he refused to have the labs drawn. The resident's 04/10/18 quarterly MDS documented his cognition was intact, he exhibited no delirium/mood issues/psychosis/behaviors/wandering, he did not reject care, and he required extensive assistance from staff to being dependent of staff for his activities of daily living (ADLs). At 4:05 PM on 06/15/18 Resident #22's primary physician stated since the resident's signs and symptoms of an UTI were self reported, a CBC and BMP would offer more definitive clinical proof of an infection and hydration issues. He reported STAT labs were requested to make quick treatment decisions. He commented Resident #22 had a history of refusing some lab draws, but he could not remember if the facility had notified him of refusals on 01/15/18 and 02/20/18. However, he stated it was his expectation that he be notified of all care refusals, including lab draws, so he could decide how to improve the resident's compliance. At 9:42 AM on 06/15/18 the Director of Nursing (DON) stated Resident #22 was known to refuse	F 773	Director of nursing will report the findings 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 Quality Assurance and Performance Improvement committee can modify this plan to ensure a facility remains in substantial compliance. 4. Responsible Party: Effective 06/20/18, the Administrator and Director of Nursing are responsible to ensure implementation of this plan of correction for this alleged noncompliance and to ensure the facility remains in substantial compliance.	

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F 773	Continued From page 25 lab draws. However, he reported his expectation was that all refusals be documented in the resident's medical record along with documentation that the resident's primary physician was notified of the refusals. He explained that scheduled labs were drawn by a phlebotomist who usually arrived in the facility sometime between 7:00 AM and 10:00 AM. According to the DON, this phlebotomist had failed to document lab draw refusals in the past. He commented STAT labs were drawn by the facility staff, and were transported to the hospital for analysis. The DON stated a CBC would determine if a resident had an elevated white blood cell count which was indicative of infection, and a BMP might help determine if a resident was dehydrated or was experiencing impaired kidney function. The DON reported he was unable to say for sure why the labs ordered for Resident #22 on 01/12/18 and 02/19/18 were not drawn.	F 773		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		6/20/18

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F 812	Continued From page 26 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to keep cold salads made with mayonnaise at or below 41 degrees Fahrenheit during operation of the trayline. Findings included: During observation of food preparation on 06/13/18 at 10:10 AM the cook was observed assembling pasta and tuna salads. She added mayonnaise and spices to cooked macaroni noodles. and added mayonnaise, pickle relish, and spices to canned tuna. On 06/13/18 the lunch trayline operation started at 11:52 AM. The pasta and tuna salads were stored in tray pans embedded in an ice bath on a cart away from the steam table where hot foods were being held. On 06/13/18 at 11:55 AM tuna salad was placed on a plate, covered, and placed in a meal cart. On 06/13/18 at 11:57 AM tuna and pasta salad were placed on a plate and covered. On 06/13/18 at 11:58 AM a calibrated thermometer used to check the temperature of the salads registered 48.1 degrees in the pasta salad, and registered 47.2 degrees in the tuna salad. Review of the trayline temperature log revealed a beginning temperature was not recorded for the	F 812	F 812 QAPI 1. Process that lead to the deficiency: The alleged noncompliance resulted when the facility failed to maintain cold tuna and pasta salads at or below 41 degrees Fahrenheit on 6/13/18 during operation of the lunch tray line. 2. Correction for specific deficiency cited: The non-plated salad was re-refrigerated to below 41 degrees Fahrenheit. All residents have the potential to be affected by the deficient practice. All dietary staff were inserviced on 6/13/18 by the District Manager of Dietary Service: a.On the proper guidelines of food temperature n b.On preparing cold food items the day before the item is served. c.Place cold food in shallow pans to ensure food remains at the proper temperature d.Record food temperatures in the Food Log Book 3. The monitoring processes and systemic changes to ensure plan of correction is effective: Effective 06/13/18, the Dietary Manager will monitor accuracy of food temperature logs weekly. The District Manager of	

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F 812	Continued From page 27 pasta and tuna salads as the 06/13/18 lunch trayline began operation. At 12:07 PM on 06/13/18 the dietary manager (DM) stated cold salads were made the same day as they were served so they could be as fresh as possible. He reported a beginning temperature was to be obtained on all cold foods, as well as all hot foods, prior to the trayline beginning operation. He commented cold salads made with mayonnaise were to be kept under 40 degrees Fahrenheit before they left the kitchen for delivery to residents. According to the DM, allowing salads made with mayonnaise to rise above 40 degrees Fahrenheit for extended periods of time could lead to bacteria formation which could potentially make residents sick. At 2:02 PM on 06/14/18 the PM Cook stated she made cold salads the same day they were served so they would be as fresh as possible. She reported they were made using chilled ingredients, were stored in the reach-in refrigerator, and were brought to the trayline a tray at a time so the heat of the kitchen did not increase the internal temperature of the salads above 40 degrees Fahrenheit. She commented cold salads should be kept chilled in order to avoid potential growth of bacteria. At 11:10 AM on 06/15/18 the AM Cook stated she made cold salads on the same day they were to be served so they would be very fresh. She reported they were stored in the reach-in refrigerator until the trayline began operation, and then they were stored over ice until all resident plates had been prepared. She commented this procedure was followed in order to ensure that the salads remained below 40 degrees	F 812	Dietary Service and/ or the Registered Dietitian will audit the food temperature logs weekly for 4 weeks, then monthly for 3 months or until a pattern of compliance is maintained. Effective 06/20/18, the Dietary Manager will report the findings to the Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan for 3 months or until a pattern of compliance is maintained. The Quality of Assurance and Performance Improvement committee can modify this plan to ensure the facility remains in substantial compliance. 4.Responsible Party: Effective 06/20/18, the Administrator and District Manager of Dietary Service are responsible to ensure implementation of this plan of correction for this alleged noncompliance and the ensure the facility remains in substantial compliance.	

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F 812	Continued From page 28 Fahrenheit while they were in the kitchen. According to this cook, this procedure helped to make sure residents did not get sick from foodborne illness.	F 812		
F 865 SS=F	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 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 interview and record review the facility's quality assurance (QA) committee failed to prevent the reoccurrence of deficient practice related to (1) food procurement, storage, preparation and service and (2) quality of care which resulted in repeat citations at F812 and F684. The re-citing of F812 and F684 during the last year of federal survey history showed a pattern of the facility's inability to sustain an effective QA program.	F 865	F 865 QAPI 1. Process that lead to the deficiency: The alleged noncompliance resulted when the facility failed to maintain implemented procedures, and monitor interventions of an effective Quality Assessment and Assurance program in the area of Food procurement, storage, preparation and service and quality of care. On 6/13/18 the dietary manager	6/20/18

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F 865	Continued From page 29 Findings included: This tag is cross-referenced to: F812: Failure to provide food procurement, storage, preparation and service: Based on observation and staff interview the facility failed to keep cold salads made with mayonnaise at or below 41 degrees Fahrenheit during operation of the trayline. Review of the facility's survey history revealed F812 was cited during a 07/06/17 federal monitoring survey, and was re-cited during the current 06/15/18 annual recertification survey. F684: Failure to provide quality of care: Based on observation, staff interviews and record review the facility failed to provide care to prevent moisture associated skin damage for 1 of 1 residents (#73). Review of the facility's survey history revealed F684 was cited during a 07/06/17 federal monitoring survey, and was re-cited during the current 06/15/18 annual recertification survey. An interview was conducted on 06/15/18 at 12:05 PM with the Administrator and the Director of Nursing. The Administrator said that the current owners of the facility were not in the building when the citations occurred last year. She reported that the new owner was making many improvements in the delivery of care and services provided by identifying opportunities for improvement on a daily basis and meeting with direct care staff routinely to identify concerns. She reported that the QA committee met monthly to review performance improvement plans.	F 865	implemented a Quality Assurance audit tool for: a.The proper guidelines of food temperature for service b.On preparing cold food items the day before the item is served. c.Placing cold food in shallow pans to ensure food remains at the proper temperature d.Recording food temperatures in the Food Log Book This audit is to be completed weekly for 4 weeks, then monthly for 3 months or until a pattern of compliance is maintained. On 06/18/18, the Director of Nursing or assistant director of nursing and the wound care nurse will monitor compliance by observing 5 incontinent residents weekly to validate timely incontinent care and that there is no moisture associated skin damage. This process will occur Monday thru Friday for 2 weeks, then weekly for 2 weeks, then monthly for 3 months or until a pattern of compliance is maintained. 2. Correction for specific deficiency cited: All residents have the potential to be affected by the deficient practice of failing to maintain an effective Quality Assessment and Assurance Program. On 06/20/18 members of the Quality Assurance team were reeducated by the Administrator. This includes the Purpose and Responsibility of the Quality Improvement Committee, the Quality Assurance team members, and meeting	

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F 865	Continued From page 30	F 865	requirements. Responsibilities: 1. Assuring the activities as directed toward the maintenance of good care and the resolution of problems that have potential for improvement in resident care. 2. Assuring that written criteria and or standards of care provided against which the data derived from assessment activities may be measured and problems identified 3. Assuring that appropriate actions are implemented to eliminate or reduce identified problems to the greatest degree reasonably possible that any corrective action has been adequate by subsequent monitoring. 4. Assuring that the effectiveness of the Facility program is reappraised annually. 5. This committee also is responsible for the duties of the Pharmacy committee, medication review committee and the Infection control committee. 3.The monitoring processes and systemic changes to ensure plan of correction is effective: Beginning on 06/18/18, the Administrator will complete a kitchen inspection audit monthly x 3 to maintain implemented procedures and monitor interventions of an effective Quality Assessment and Assurance program in the area of Food and Nutritional services. The Administrator will review the Monthly audit findings with the Quality Assurance committee.	

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F 865	Continued From page 31	F 865	On 06/18/18 the Director of Nursing or assistant director of nursing and the wound care nurse will monitor compliance by observing 5 incontinent residents weekly to validate timely incontinent care and that there is no moisture associated skin damage. This process will occur Monday thru Friday for 2 weeks, then weekly for 2 weeks, then monthly for 3 months or until a pattern of compliance is maintained. The Monthly Quality Assurance Meeting is attended by the Director of Nurses, Assistant Director of Nursing, Minimum Data Set Coordinator, Therapy, Health Information Manager, Dietary Manager, Social Worker, Administrator and Medical Director. Deficits that are identified during the monitoring process will be addressed through the facility Quality Assurance program. 4.Responsible Party: Effective 6/20/18, the Administrator is responsible to ensure implementation of this plan of correction for this alleged noncompliance and to ensure the facility remains in substantial compliance.	