STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	C 06/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	**7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID #GOID11.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to honor	F 561	Filing the plan of correction does not constitute that the alleged deficiencies did	6/27/18

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

Electronically Signed | 06/25/2018

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F 561	Continued From page 1 residents' preference for eating in his room for 1 of 1 resident (Resident #34) reviewed for choices. The findings included: Resident #34 was admitted to the facility on 05/09/18 with diagnoses which included recent fall at home with active head trauma (bleed), hypertension (HTN), atrial fibrillation, convulsions and peripheral vascular disease (PVD). Review of Resident #34s admission Minimum Data Set (MDS) assessment dated 05/16/18 revealed he was moderately cognitively impaired for daily decision making, required extensive assistance of 1-2 persons with most activities of daily living (ADL) and was frequently incontinent of bowel and bladder. Review of Resident #34s admission Care Area Assessment (CAA) summary for ADL dated 05/21/18 revealed he was admitted to the facility after an acute hospitalization following a fall with head trauma on 04/05/18. He was admitted for short term rehab and other diagnoses included atrial fibrillation, HTN, gastro-esophageal reflux disease (GERD), convulsions and PVD. Resident is extensive assistance of 1-2 persons with ADL and transfers and nursing staff to provide assistance in a timely manner. Therapy to work with the resident as ordered by the physician. The family is very supportive in the resident's care and per the family the resident may need long term placement due to his wife's illness and her starting chemo treatment. He is frequently incontinent of bowel and bladder and nursing staff is to assist with toileting and or incontinent care at least every 2 hours and as needed. Monitor skin integrity with each	F 561	in fact exist. The plan of correction is filed as evidence of the facility□s desire to comply with the requirements and to continue to provide high quality of care. F561 Resident #34 was met with and his preferences have been honored and are clearly documented in the resident profile. All nursing staff were educated by the Staff Development Coordinator on 6/22/18 regarding communication of resident□s preferences and the importance of allowing resident choice. Staff failed to follow through with the communication system in place by the facility. The facility will promote and facilitate resident self determination of all residents who are cognitively able to make choices. This will be accomplished by the development of a resident preference interview form which will include resident preferences regarding the time the resident wishes to get out of bed as well as where the resident would like to receive his/ her meals. This form was developed by the Administrator and will be completed by 6/26/18 for all residents by the Administrative nursing staff and the Social Worker and all resident profiles will be updated accordingly. All staff were educated by the Staff Development Coordinator on 6/1/18 regarding the importance of following resident□s choices in all aspects of his/ her life that are significant to the resident. The resident preference interview will be completed for new admissions and quarterly at the care plan conference. An	

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F 561	Continued From page 2 incontinent episode and nursing skin audits to be performed weekly and address any issues noted. The resident is at risk for falls related to a previous fall with right sided subdural hematoma, generalized weakness and physical deconditioning. Nursing staff to anticipate needs and keep call bell within reach. Resident doesn't use call bell at times, staff frequently monitors and encourages the use of the call bell. He is at risk for skin impairment related to decreased mobility and generalized weakness. He received an antidepressant one day during the look back and family requested it to be discontinued. Family was concerned about who started the antidepressant at the previous facility without consulting the family. Family is however concerned that he may get depressed with being in the facility. A psyche consult was completed and the family is in agreement with psyche services to see him. Pharmacy is to monitor his medication and if placed back on an antidepressant or other medication will monitor monthly for recommendation for reduction. Review of Resident #34s care plan dated 05/11/18 revealed he was dependent on staff assistance for all ADL except eating related to his fall with injury, generalized weakness and physical deconditioning. The goal was measurable with appropriate interventions for the resident. A review of Resident #34s preferences obtained on admission revealed that he didn't like eating in the dining room. An observation and interview with the resident and family member at the bedside on 05/29/18 at 10:21 AM revealed the staff had been getting the resident up between 5:00 and 5:30 AM every	F 561	audit tool was developed to monitor that the preference interview has been completed, that the resident preferences are communicated via the resident profile and that the preferences are being honored. The Resident Preference audit tool will be completed by the Director of Nursing / MDS Coordinators for 25% of all residents weekly for 8 weeks, then monthly for 4 months. The need for further audits will be determined based on the results of the audits for the prior 6 months. Results of the audits will be reviewed and analyzed by the Director of Nursing at the monthly QAPI meetings. The Director of Nursing is responsible for implementing the acceptable plan of correction.	

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F 561	Continued From page 3	F 561		

morning. The family member stated they washed him up and got him dressed and rolled him out to the nurse's station or the TV room so he would be ready for breakfast in the dining room. The resident who was sitting up and dressed in his wheelchair stated he had not wanted to get up that early and had not wanted to eat in the dining room. The family member stated they had told someone (could not remember name) on admission that he did not want to eat in the dining room.

An observation on 05/30/18 at 8:29 AM revealed the resident dressed and sitting in his wheelchair outside his room in the hallway with his head down and eyes closed. Resident #34 was easily aroused and stated he had been gotten up too early and had eaten breakfast in the dining room.

A phone interview on 05/30/18 at 11:12 PM with nurse aide (NA) #1 revealed 3rd shift had a list of residents they got up early daily. NA #1 stated they washed them up, got them dressed and if they were not ready to get up would let them lie back down. She stated if the residents were ready to get up they would put them in their chair and before they left would put them out at the nurse's station or in the TV room so they were close to the dining room and would be ready for breakfast. NA #1 stated she had been getting Resident #34 up early and stated he was on the list of residents to get up early. She stated she was looking at the list and Resident #34 was actually not on the list but stated they had been getting him up early for the dining room. NA #1 stated he had woke up early yesterday so they had gotten him up, dressed him and taken him to the TV room to wait for breakfast in the dining room. NA #1 stated she was not sure about his

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F 561	Continued From page 4 preferences and would have to look at them. An interview on 06/01/18 at 2:50 PM with the Director of Nursing (DON) revealed her expectation was for residents' preferences to be honored. The DON stated Resident #34 should not have been gotten up early and taken to the dining room to eat his breakfast when it was not his preference.	F 561		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) to reflect a resident's discharge status for 1 of 1 resident (Resident #99) reviewed for hospitalization. The findings included: Resident #99 was admitted to the facility on 04/04/18 with diagnoses which included type 2 diabetes mellitus, malignant neoplasm of the breast, depressive episodes, pain, and wedge compression fracture of the lumbar vertebra. The resident was discharged from the facility on 04/22/18. The admission MDS revealed Resident #99 was cognitively intact for daily decision making and required limited assistance of 1 for most activities of daily living (ADL).	F 641	F641 For Resident #99, the discharge MDS dated 4/24/18 was modified on 6/1/18 to reflect that the resident was discharged to the community. The MDS Coordinator failed to follow the policy for properly coding assessments. An audit will be completed by the MDS Coordinator for 100% of all residents discharged within the last 60 days to verify that discharge location is accurately coded on the discharge MDS assessment. Assessments will be modified as needed. This will be completed by 6/26/18. Education was provided to the Interdisciplinary Care Plan team on 6/22/18 to include MDS Coordinators, Social Services, Activity Director, Dietary Manager, and Therapy Manager by the Director of Nursing/ RN Consultant	6/27/18

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F 641	Continued From page 5 Review of a progress note written by the Social Worker on 04/22/18 revealed the resident was discharged home with her daughter and home health was to follow for physical therapy, occupational therapy, nursing and nurse aide (NA). There were no equipment needs and no issues or concerns upon discharge. Review of the physician's discharge summary dated 04/24/18 revealed the resident was discharged as stable with follow up with home health. Review of the discharge MDS dated 04/24/18 revealed Resident #99 was coded as discharged to an acute hospital. An interview with the MDS nurse on 06/01/18 at 1:52 PM revealed the discharge was coded incorrectly. The MDS nurse stated the discharge should have been coded as community because Resident #99 discharged home with her daughter and home health follow up. The MDS nurse stated it had been coded incorrectly and she would correct it immediately. An interview with the Director of Nursing on 06/01/18 at 2:50 PM revealed she expected the MDS assessments to be coded correctly to reflect the resident's current status.	F 641	regarding the assessment process and the importance of coding the MDS accurately. An audit tool was developed to monitor MDS assessments for proper coding of discharge locations on the discharge MDS assessment. Audits will be completed by the Director of Nursing/ RN Consultant for 100% of all discharged residents weekly for 8 weeks, then monthly for 4 months. The need for further audits will be determined based on the results of the audits for the prior 6 months. Results of the audits will be reviewed and analyzed by the Director of Nursing at the monthly QAPI meeting. The Director of Nursing is responsible for implementing the acceptable plan of correction.	
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	F 684		6/27/18

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F 684	Continued From page 6 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to initiate the bowel protocol for 1 of 5 residents reviewed for unnecessary medication use (Resident #18). The findings included: Resident #18 was admitted to the facility on 11/22/17 with diagnoses of orthostatic hypotension, non-Alzheimer's dementia, Parkinson's disease, adult failure to thrive, anxiety, depression, and psychotic disorder. Review of the quarterly Minimum Data Set dated 04/23/18 revealed Resident #18 was severely cognitively impaired and required extensive assistance with toileting. Review of the care plan dated 04/25/18 revealed Resident #18 was a long term resident with diagnoses of hospital related psychosis, anxiety and depressive disorder, that is using psychotropic medications, placing the resident at risk for adverse reactions related to the use of those medications. The goal was for Resident #18 to remain free of any discomfort or adverse side effects related to the use of psychotropic medications. The interventions included: administer medications as ordered. Observe for possible side effects every shift: high fever, muscle rigidity, orthostatic hypotension, sedation, and anticholinergic effects (such as constipation).	F 684	F684 There were no adverse effects to Resident #18 and he had a bowel movement on 5/20/18. The nursing staff failed to follow the system for monitoring bowel movements that was in place by the facility. All residents□ bowel records were reviewed by the Director of Nursing on 6/22/18 for the prior 30 days and the bowel protocol was followed appropriately for residents requiring the bowel protocol criteria. The process has been changed in that the bowel records will be reviewed daily by each hall nurse and the protocol initiated and followed as necessary. The Director of Nursing/ Nursing Supervisor will also review the bowel records each morning for the prior day to ensure compliance that the resident received the appropriate follow up with Milk of Magnesium, Dulcolax suppository, or fleets enema as needed. Licensed Nursing staff were educated by the Staff Development Coordinator on 6/1/18 regarding the importance of following the bowel protocol and the process for monitoring bowel records and administering ordered medications when necessary. An audit tool was developed to monitor that the bowel protocol is initiated if a resident does not have a bowel	

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F 684	Continued From page 7 Review of the facility bowel records from 04/30/18 through 05/30/18 revealed Resident #18 had no bowel movements documented on 05/15/18, 05/16/18, 05/17/18, 05/18/18, and 05/19/18 for a total of 5 days without a bowel movement. Review of the facility standing orders for bowel protocol revealed: if no bowel movement in 3 days give milk of magnesium, if not effective in 12 hours give dulcolax suppository, and if not effective in 12 hours give fleets enema. Review of the Medication Administration from 05/01/18 through 05/31/18 revealed Resident #18 had not received any milk of magnesium, dulcolax suppository, or a fleets enema. An interview conducted on 05/31/18 at 10:15 AM with Nurse #1 revealed she should have started the bowel protocol for Resident #18 after he went three days without a bowel movement but she missed it. She stated she reviewed the bowel movement records daily but overlooked the five days that Resident #18 did not have a bowel movement documented. An interview conducted on 06/11/18 at 12:03 PM with the Director of Nursing revealed it was her expectation for nurses to start the bowel protocol for any resident that did not have a bowel movement in three days.	F 684	movement in 3 days and that the appropriate interventions were implemented. Audits will be completed by the Nursing Supervisor/ Staff Development Coordinator for 25% of all residents weekly for 8 weeks, then monthly for 4 months. The need for further audits will be determined based on the results of the audits for the prior 6 months. Results of the audits will be reviewed and analyzed by the Director of Nursing at the monthly QAPI meetings. The Director of Nursing is responsible for implementing the acceptable plan of correction.	
F 690 SS=D	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	F 690		6/22/18

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F 690	Continued From page 8 maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to ensure a resident's catheter bag was not in contact with the floor and ensure it was in an appropriate privacy bag for 1 of 1 residents (Resident #38) reviewed for catheters.	F 690	F690 Facility staff identified the issue with the catheter bag on 5/19/18 at approximately 2:00 PM and the catheter bag was placed in an appropriate privacy bag and tubing was no longer touching the ground without prompting by the surveyor. Resident #38	

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F 690	Continued From page 9 Findings included: Resident #38 was admitted to the facility on 04/20/18 with diagnoses that included: retention of urine, atrial fibrillation, insomnia, Parkinson's disease and urinary tract infection among others. A review of Resident #38's most recent Minimum Data Set (MDS) dated 04/27/18 and coded as an Admission Assessment revealed Resident #38 to be moderately impaired cognitively with no behaviors or instances of rejection of care. Resident #38 was coded as requiring extensive assistance with personal hygiene and was totally dependent on staff for toileting. Resident #38 was coded as being frequently incontinent of bowel. A review of Resident #38's care plan revealed a care plan area for "Resident requires an indwelling urinary catheter R/T urinary retention". Interventions included "Do not allow tubing or any part of the drainage system to touch the floor" and "Store collection bag inside a protective dignity pouch". An observation of Resident #38 on 05/29/18 at 10:34 AM revealed him to be in his room, in his wheelchair mobilizing towards his bathroom. Further observation at this time revealed Resident #38's catheter bag to be inside of a white, cloth, bag of unknown type and was dragging the floor. Additional observation at this time revealed the catheter tubing to be touching and dragging across the ground while Resident #38 continued to mobilize towards the bathroom. An observation of Resident #38 on 05/29/18 at 1:02 PM while Resident #38 was leaving the main dining room after his lunch meal revealed the	F 690	had no adverse effects. Staff failed to follow through with system in place for catheter storage and transport. There are no other residents at the facility currently utilizing foley catheters. Nursing staff have been educated by the Staff Development Coordinator on 6/1/18 regarding the use of privacy drainage bags as well as keeping drainage tubing off the floor. The nursing supervisor will include observations of any resident with a foley catheter during the morning rounds to validate the proper privacy bag is in place and the tubing is not on the floor. An audit tool was developed to monitor that the proper privacy bag is in place and that the drainage tubing is off the floor. Audits will be completed by the Nursing Supervisor/ Staff Development Coordinator for all residents utilizing a foley catheter daily for 2 weeks, then 3 times a week for 6 weeks, then monthly for 4 months. The need for further audits will be determined based on the results of the audits for the prior 6 months. Results of the audits will be reviewed and analyzed by the Director of Nursing at the monthly QAPI meetings. The Director of Nursing is responsible for implementing the acceptable plan of correction.	

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F 690	Continued From page 10 resident's catheter bag to continue to drag the ground while he mobilized along with the tubing and the catheter bag continued to be stored in the white cloth bag of unknown type. During an interview with Nurse Aide #4 on 06/01/18 at 11:01 AM revealed she had worked on 5/29/18 and noted that Resident #38's catheter bag was in a pillowcase. She stated she did not know who had initially put it in a pillowcase but reported the catheter bag should not have been in a pillowcase or touching the ground. She further reported "they probably did not know where the privacy bags were". An interview with Nurse #3 on 06/01/18 at 11:12 AM revealed she had worked on the hall and with Resident #38 on 05/29/18 but could not recall seeing his catheter bag on the floor or in a white pillowcase. She further reported that Resident #38's catheter bag and tubing should not touch the ground and that the catheter bag itself should not be in anything other than an appropriate privacy bag. On 06/01/18 at 11:32 AM during an Interview with the Director of Nursing it was revealed it was her expectation that proper infection control policies be followed and that catheter bags and tubing not touch or drag the floor and that catheter bags be stored in an appropriate privacy bag when hung on the wheelchair.	F 690		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 761		6/15/18

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 11 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to discard expired medications from 1 of 1 medication rooms and 1 of 3 medication carts, the 600 hall medication cart. The findings included: Observation of the medication room on 06/01/18 at 12:13 PM revealed the following medications that were expired, in the cabinet and available for use. 1. (3) bottles of Folic Acid 400 mcg 100 tablet each - all full bottles that expired on 02/2018	F 761	F761 All expired medications were removed from the medication room and medication cart immediately. There have been no adverse effects to any residents. Pharmacy staff failed to remove the medications per facility policy on 5/10/18. Licensed Nursing staff have been educated by the Staff Development Coordinator on 6/1/18 regarding the importance of clearly marking the expiration dates, not administering expired medications, and properly disposing of expired medications. An audit tool was developed to monitor	

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F 761	Continued From page 12 2. (1) bottle of Deep Sea Premium Saline Nasal Moisturizing Spray - unopened that expired 04/2017 3. (2) boxes of Famotidine 10 mg tablets - unopened with 30 tablets each and expired 05/2018 4. (1) opened bottle of Nature's Blend Super B Complex with C - approximately 75 capsules in the bottle that expired 05/2018 5. (3) bottles of Zinc 50 mg containing 100 tablets each unopened and expired on 02/2018 6. (4) bottles of Vitamin B12 250 mg tablets containing 120 tablets each unopened and expired on 05/2018 An interview on 06/01/18 at 12:34 PM with the Supervising RN revealed the medications should have been removed from the cabinet and discarded. Observation of the 500 hall cart found no expired medications. Observation of the 600 hall cart on 06/01/18 at 1:35 PM revealed the following medications that were expired, on the cart and available for use. 1. (1) bottle of Vitamin B 12 350 mcg opened bottle with approximately 75 tablets in the bottle and expired on 05/2018 2. (1) bottle Cerovite Senoir tablets opened bottle with 10 tablets left in the bottle and expired on 05/2018 3. (1) box of Famotidine 10 mg tablets opened with 24 tablets left in the box of 30 tablets and expired on 05/2018 4. (1) bottle of Zantac 150 mg tablets opened with 24 tablets left in the bottle of 30 tablets and expired on 05/2018	F 761	that expired medications are removed and medication stock is rotated. Audits will be completed weekly by the Staff Development Coordinator/ Nursing Supervisor. Pharmacy will continue to monitor medications rooms and medication carts monthly. Results of the audits will be reviewed and analyzed by the Staff Development Coordinator at the monthly QAPI meetings. The Director of Nursing is responsible for implementing the acceptable plan of correction.	

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F 761	Continued From page 13 An interview on 06/01/18 at 1:55 PM with the 600 hall nurse revealed the medications should have been removed from the medication cart and discarded. An interview on 06/01/18 with the Director of Nursing (DON) revealed she expected all expired medications to be removed from the medication room and the carts.	F 761		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of	F 791		6/27/18

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F 791	Continued From page 14 what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to make a referral for dental services for a resident having trouble eating meals for 1 of 3 residents reviewed for dental services (Resident #11). The findings included: Resident #11 was admitted to the facility on 11/21/17 with diagnoses of Alzheimer's disease, anxiety, depression, and chronic obstructive pulmonary disease. Review of the quarterly Minimum Data Set (MDS) dated 04/10/18 revealed Resident #11 was moderately cognitively impaired. Review of the admission MDS dated 11/28/17 revealed Resident #11 had no natural teeth or tooth fragments. Review of the nurse's notes dated 11/27/17	F 791	F791 Resident #11 was seen by the facility dentist on 5/4/2018 for complete oral exam to include assessment for dentures. Consult states there is a 50/50 rate of success for the upper and the odds on the lower are very, very low. The prior approval process was initiated. Resident has had a weight gain since admission. Nursing staff failed to follow facility dental policy. An audit will be completed by 6/26/18 for all long-term residents to validate that they have received appropriate dental services to include the oral exam and evaluation for dentures/ denture adjustments as appropriate and referrals completed if necessary. Licensed Nursing staff have been educated by the Staff Development Coordinator on 6/22/18 regarding the	

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F 791	Continued From page 15 revealed: Resident #11's family member approached this nurse regarding diet. Son stated, "She is having issues with her teeth and can't chew her food and we can't afford to get her new ones." Per nursing diet change to mechanical soft at this time. Dietary informed. Review of Resident #11's medical record revealed no dental referral in 11/2017 or 12/2017. It further revealed no speech therapy referral during 11/2017 or 12/2017. An interview conducted on 05/31/18 at 10:35 AM with the Unit Manager revealed Resident #11's son came to her shortly after she was admitted to the facility and told her Resident #11 could not chew her food because she was having problems with her dentures. She stated she wrote an order to downgrade her diet to mechanical soft but did not assess her dentures. The Unit Manager stated if a resident diet was downgraded a referral should have been made for dental services and a speech evaluation but she did not make a referral for Resident #11 for either service. An interview conducted on 06/01/18 at 10:30 AM with the Registered Dietician (RD) revealed if a resident was having problems chewing it was her expectation for a speech therapy and dental referral to be made to determine the cause of the chewing problem. She stated the nurse could downgrade the diet but should always make a referral for follow up. An interview conducted on 06/01/18 at 1:08 PM with the Director of Nursing revealed it was her expectation for a referral for dental services to be made if a resident was having problems chewing	F 791	importance of obtaining routine and emergency dental care to include prompt referrals for lost or damaged dentures and completing a speech and dental referral when a diet is downgraded. An audit tool was developed to monitor that residents have received routine dental care, that resident□s dentures are in good condition and fit appropriately, and if a diet has been downgraded, that the appropriate dental and speech referrals have been made. Audits will be completed by the Nursing Supervisor/ Staff Development Coordinator for 25% of all residents weekly for 8 weeks, then monthly for 4 months. The need for further audits will be determined based on the results of the audits for the prior 6 months. Results of the audits will be reviewed and analyzed by the Director of Nursing at the monthly QAPI meetings. The Director of Nursing is responsible for implementing the acceptable plan of correction.	

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F 791	Continued From page 16 her food related to her dentures. She stated it was acceptable for the nurse to downgrade the resident's diet but a follow up with dental or speech therapy services should always be initiated.	F 791		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor the interventions the committee put into place following the recertification survey of 06/15/17. This was for one deficiency that was originally cited in June of 2017 and was subsequently recited on the current recertification and complaint survey of 06/01/2018. The two federal surveys of record show a pattern of the facility's inability to sustain and effective Quality Assurance Program. The findings included: This tag were cross referenced to: F 641: Accuracy of assessments: Based on record reviews and staff interviews the facility failed to accurately code the Minimum Data Set to reflect a resident's discharge status for 1 of 1 resident reviewed for hospitalization (Resident	F 867	F867 Education was provided to the Interdisciplinary Care Plan team on 6/25/18 to include MDS Coordinators, Social Services, Activity Director, Dietary Manager, and Therapy Manager by the Director of Nursing regarding the assessment process and the importance of coding the MDS accurately. The facility failed to follow the QAPI plan to review issues from past surveys and evaluate current plans for effectiveness. Education was provided to the facility Quality Assurance & Performance Improvement (QAPI) committee members to include the Medical Director, Staff Development Coordinator, Treatment Nurse, MDS Coordinators, and Dietary Manager by the Administrator and Director of Nursing on 6/25/18 regarding the QAPI committee and program. The education includes the objectives of the QAPI	6/27/18

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F 867	Continued From page 17 #99). During the recertification survey of 06/15/17 the facility was cited at F 641 for failing to accurately code the admission Minimum Data Set for range of motion (Resident #15) and Level II Preadmission Screening and Resident Review (Resident #27) for 2 of 14 sampled residents. An interview conducted with the Administrator on 06/01/18 at 3:07 PM revealed they completed all of the plan of correction quality assurance monitoring for F 641 and thought they had corrected the problem. She stated they will do ongoing monitoring of this issue going forward.	F 867	program including to identify and review issues from past surveys and evaluate the current plan for its effectiveness and change the plan as needed, the purpose of the QAPI program to provide a means for resident care and safety issues to be resolved, and how the committee monitors issues and follows up with unresolved issues that have been identified. The QA policy was reviewed by the Administrator. The policy states that the facility shall develop, implement, and maintain an ongoing program designed to monitor and evaluate the quality of resident care, pursue methods to improve care quality, and to resolve identified problems. No changes to the policy were necessary. The QA Self Evaluation audit tool monitors the QA committee and its functions and monitors if the committee has a current plan in place, if the committee identifies who is responsible to oversee the plan, if the plan is working, if it is not working have changes been put into place to improve, if the outcome is measurable, if the project has been successful, and if the plan can be considered resolved. The audit tool will be completed by the sub-committee to include the Director of Nursing, Staff Development Coordinator, and MDS Coordinators twice a month for 6 months. Ongoing use of the Self-Evaluation tool will be determined based on the results of the audits for the prior 6 months. The results of the QA Self-Evaluation tool	

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F 867	Continued From page 18	F 867	will be reviewed and analyzed by the Director of Nursing at the monthly QAPI meetings and changes or recommendations will be discussed as necessary. The Director of Nursing is responsible for implementing the acceptable plan of correction.	