STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING _____ B. WING _____	C 06/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616

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F 000	INITIAL COMMENTS A follow-up complaint survey, recertification and complaint survey was conducted by the Divison of Health Service Regulation, Nursing Home Licensure and Certification Section on 6/10/18 through 6/15/18. The deficiencies at F0580, F0600, F0636, F0642, F0684 and F0689 were in compliance as of 6/15/18 from the complaint survey (Event #HC8412). However, the facility remained out of compliance with the following deficiencies re-cited during the revisit, recertification survey and complaint survey: F0550 and F0585. Additional deficiencies were identified during the recertification and complaint survey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility	F 550		7/23/18

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

Electronically Signed | 07/09/2018

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F 550	Continued From page 1 must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews the facility failed to provide care in a manner to maintain the resident ' s dignity by not providing timely incontinence care for a resident that had a bowel movement (Resident #117). This was evident in 1 of 4 residents reviewed for dignity. Findings Included: Resident #117 was admitted to the facility on 5/23/18 and diagnoses included limitation of activities due to disability, abnormalities of gait, history of falls, diabetes, atrial fibrillation, chronic kidney disease and depressive disorder.	F 550	F 550 Resident Rights/ Exercise of Rights Root Cause Analysis Based on the root cause analysis by the facility administrative staff and the facility Executive Director the facility staff (Certified nursing assistant, CNA ,) did not follow the expectation for providing ADL care for a resident needing assistance Immediate Actions On 6/10/18 learning of the need of the resident by the Executive Director, the Executive Director had the resident changed by C N A # 5 and the nurse. The C N A was counseled and re-educated by	

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F 550	Continued From page 2 Review of a skin condition assessment dated 5/23/18 for Resident #117 revealed she had a rash on her perineal area and abdominal folds. Skin excoriation to left buttocks and perineum and moisture associated skin damage (MASD). An admission minimum data set (MDS) dated 5/30/18 for Resident #117 identified she was always incontinent of bowel and bladder, required extensive two-person assist with toilet use and personal hygiene, had skin lesions, rashes and cuts and her cognition was intact. A care plan dated 5/30/18 for Resident #117 stated she was always incontinent of bowel and urine. Interventions included to observe her skin daily for irritation and redness, assist to the bathroom or commode as needed and to assist with perineal cleansing as needed. An interview with Resident #117 on 6/12/18 at 8:20 am revealed on Sunday, 6/10/18 she had urinated and had a bowel movement in her brief. Resident #117 stated she turned on the call light and observed the nursing assistant (NA) go to the room across the hall from her to answer a call light. She explained she hollered out to the NA that she had her call light on first and needed to be changed. The NA told her she had 4 other residents in front of her and then she would come and change her. Resident #117 stated she got upset because she had a sore on her bottom and staying in the soiled brief was going to make her skin worse. She added she started hollering out because she really wanted to be cleaned up and didn ' t ' understand why she had to wait when her call light was on first. Resident #117 went on to explain that the Admission Director came into her room and tried to appease her and she	F 550	the ED. Identification of others: Effective 7/10/18 - 7/13/18 the Director of Social Work and Unit Coordinator will interview all residents with a BIMS score of 8 or above, to identify if call lights are being answered timely and incontinent care was being provided timely. This will be documented on an interview record and a copy will be maintained in a binder in ED office. SYSTEMIC CHANGES Starting 7/9/18 □- 7/13/18 the Director of Nursing Services and or Staff Development Coordinator will complete 100% education for all licensed nurses and certified nursing assistants. This education will include, answering of call lights timely as well as the timeliness of providing incontinent care. This education will be completed by 7/13/18. Any licensed nurses and certified nursing assistants not educated prior to 7/13/18 will not be allowed to work until educated. Effective 7/9/18 all new hire licensed nurses and certified nursing assistants will receive orientation regarding, the answering of call lights timely as well as the timeliness of providing incontinent care. MONITORING PROCESS The Director of Nursing Services, Staff Development Coordinator and or Unit Coordinator will monitor the compliance of answering call lights timely and the timeliness of providing incontinent care by completing a random observation audit. This audit will include a random observation of 10 call lights daily for 2	

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F 550	Continued From page 3 requested to see the Administrator. The Administrator did come to see her and told the staff to come and change her. She stated the nurse and NA eventually did come in and the NA left the room because she was still upset and yelling. The nurse got another staff member to come in and they changed her. Resident #117 stated she had laid in her stool and urine for 30 minutes to an hour before she was changed. She stated she knew how long it was because she checked the time on her cell phone. An interview on 6/14/18 at 3:44 pm with NA #5 revealed she was the NA assigned to resident #117 on Sunday, 6/10/18 on first shift. She stated she was the only NA on the hall that shift because they had pulled the other assigned NA (who was also a Med Tech) to pass medications. She explained that left her with the whole assignment of 14 residents on that hall and 3 other residents on an adjacent hall. She added the NA on the adjacent hall agreed to help her with those 3 residents. NA #5 stated she had never had the whole hall by herself and there was a delay in answering the call lights, especially if she was tied up providing care in another room. She explained after lunch, Resident #117 put her call light on and she told the resident there were a couple of residents she needed to put back to bed and then she would be in to change her. She stated Resident #117 started yelling at her and she left the room. NA #5 explained the resident used her cell phone to call the front office and someone came down and talked to her. The Administrator told her and the nurse to go in and change Resident #117. When they went in the room the resident started fussing at her again and she left the room. NA #5 stated she thought it was better for her to leave the room than get	F 550	weeks, then 10 call lights weekly for 2 weeks, then 10 call lights monthly for 3 months or until a pattern of compliance is maintained. The Director of Nursing Services will report the finding to the Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure a facility remains in substantial compliance. REPONSIBLE PARTY Effective 7/13/18 the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	

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F 550	Continued From page 4	F 550		

upset with the resident. She stated the nurse stayed and changed her and the resident had a bowel movement. NA #5 stated she was not sure how long Resident #117 had laid in her soiled brief before she was changed.

An interview on 6/14/18 at 8:42 pm with the Administrator revealed a staff member had told her Resident #117 was upset and wanted to see her. The resident told her she had her call light on and she needed to be changed. The resident explained to her that NA #5 came to answer her call light and told her she had 3 other residents ahead of her and then she would change her. The resident did tell the NA #5 she had a bowel movement. The Administrator stated she calmed the resident down and went and got the nurse and NA #5 to go in and change her. She added the nurse and NA #5 went into the resident ' s room, but before she left the hall she observed NA #5 had come back out of the room. NA #5 told her the resident was yelling at her and she didn ' t have to be spoken to like that and she wasn ' t going to change her; the nurse was going to change her. The Administrator stated she told NA #5 that was her job and to go back in and assist the nurse. She stated NA #5 was disciplined and moved to another unit. She told NA #5 she had to prioritize her work load and changing someone that had a bowel movement was a priority. The Administrator added she was not sure how long Resident #117 laid in her bowel movement before she was changed, but that it did make the resident very angry and upset. She added it was her expectation that residents care was provided timely.

A phone message was left on 6/15/18 at 9:34 am for the nurse assigned to Resident #117 on

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F 550	Continued From page 5 Sunday, 6/10/18. The message was not returned. An observation of incontinence care and skin condition was attempted on 6/15/18 at 1:35 pm and Resident #117 refused to allow the observation.	F 550		
F 582 SS=C	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.	F 582		7/23/18

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F 582	Continued From page 6 (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to use the correct "Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNFABN) form CMS (Centers for Medicare and Medicaid Services)-R-131 form for 3 of 3 residents reviewed for beneficiary protection notification. (Resident #171, #172 and #77) The facility failed to provide a timely SNFABN notice for 2 of 3 residents reviewed for noncoverage of skilled care. (Resident #171 and #172). Findings included: Record review revealed SNFABN form R-131 was mandated to be used by a skilled facility	F 582	F582 Medicaid /Medicare Coverage/Liability Notice Root Cause Analysis Based on the root cause analysis by the administrative staff and facility Executive Director it was determined that there was a lack of clear understanding of the regulatory requirement to provide a skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) prior to discharge from Medicare part A services for residents who planned to remain in the facility for long term care. Immediate Action The Director of Social Services has completed and provided the	

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F 582	Continued From page 7 effective May 7, 2018. a. Interview and record review with the Director of Social Work (DOSW) on 06/14/18 at 09:15 AM was conducted. Record review revealed the written date on the CMS 10123-NOMNC (Notice of Medicare Non- Coverage) form was dated 5/24/18 as the last covered date and date the resident signed the form. The R-131 form was not used. DOSW revealed Resident #171's last covered date for skilled care was actually 5/23/18 and stated it was a common mistake to write the wrong date. Continued interview on 06/14/18 at 09:15 AM with the DOSW who stated she was unaware of the guidance and new non-coverage notice SNFABN form (CMS-R-131). b. Interview and record review with the Director of Social Work (DOSW) on 06/14/18 at 09:15 AM was conducted. Record review revealed the written date on the CMS 10123-NOMNC (Notice of Medicare Non- Coverage) form for Resident #172 was dated 5/9/18 as the last covered date and date the resident signed the form. Further record review revealed the R-131 form was not used. Continued interview on 06/14/18 at 09:15 AM with the DOSW who stated she was unaware of the guidance and new non-coverage notice SNFABN form (CMS-R-131). c. Interview and record review with the Director of Social Work (DOSW) on 06/14/18 at 09:15 AM was conducted. Record review revealed 6/4/18 was the date coverage for skilled care would end for Resident # 77. Resident #77 signed the form on 6/1/18 but the SNFABN form-131 was not used. Continued interview on 06/14/18 at 09:15 AM with the DOSW who stated she was unaware of the guidance and new non-coverage notice	F 582	resident/family with the ABN notices for resident # 171,172,and 77 Identification of Others On 7/9/18 a 100% audit of the last 30 days of discharges was conducted by the Social Service Director to determine others who may have been affected by the alleged deficient Practice. This audit will be in a binder in the ED office. Systemic Changes On 7/9//18 education was provided the Executive Director to the Social Service Director regarding the regulatory requirements for issuing an ABN by the Regional Team. This education included that residents who remain in the facility after Medicare a services ended require an ABN be given. Beginning 7/9//2018 the Social Service Director will maintain a log of resident who are discharged from Medicare part a services and plan to remain in the facility for long term care. On this log will be the resident's name, date Medicare Part A discharge and the date the ABN was provided. The log will be kept in a binder in the Social Service Directors office along with a copy of the ABN that has been provided to long term care residents. Monitoring Beginning 7/9//18 the Executive Director (ED) of the facility will review the Medicare Part A discharge binder weekly and validate that the ABN has been provided to those long term residents who's Medicare Part A services have ended. The ED will sign the Medicare Part A discharge log daily Monday through Friday	

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F 582	Continued From page 8 SNFABN form (CMS-R-131). Interview on 06/14/18 at 09:50 AM with the Administrator who stated she had been working at the facility for only several weeks, was unaware of the R-131 form and had not reviewed the SNFABN notices provided to the residents. The Administrator indicated she expected the appropriate notice be provided timely to the residents according to the regulations.	F 582	for two weeks then weekly for 4 weeks and then monthly for 3 months. Findings will be reported to the QAPI committee for recommendations or modifications until a pattern of compliance is achieved. REPONSIBLE PARTY Effective 7/13/18 the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution	F 585		7/23/18

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F 585	Continued From page 9	F 585		

of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately

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F 585	Continued From page 10 reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to address and document the corrective action taking for grievance issues in the areas of snacks, dirty nails, and an ongoing cough, flakey skin and treatment, weight loss, and how to contact the physician for 1 of 5 residents reviewed for grievances (Resident #318).	F 585	F585 Grievances Root Cause Analysis Based on the root cause analysis by the facility administrative staff and the facility Executive Director, it was determined that the facility did not follow policy and procedure for completion and documentation of corrective actions for a grievance.	

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F 585	Continued From page 11 Findings included: A grievance from resident's #318 family dated 4/16/18 revealed the family had many concerns which included Activities of Daily living care (washing hair with a specific shampoo), Resident #318 having dirty nails, food and snack concerns, weight loss concerns, a cough for lasting 3 weeks, and that the resident's eyes were crusty. Per the grievance, the resolution only addressed the concern of weight loss, the shower schedule and the use of a special shampoo on the resident's head. The remaining areas of concerns of snacks, dirty nails, and an ongoing cough were not addressed or documented in the grievance's resolution. Per the grievance, the Director of Nursing (DON) investigated the grievance and had a 1 to 1 discussion with the family on 4/20/18. A grievance dated 5/2/18 from the social worker revealed there was a bruise on the resident's head and chest. The family wanted to know where the bruise came from and why she was not notified. The family also had a concern that the patient's skin was flakey and dry and the family wanted to know what skin care product was being used on the resident. The nurse stated that Vaseline (a cream for dry skin) was used and the family was unaware of this. The action stated that the resident was assessed from head to the toe and discoloration was noted. No other skin abnormality was noted. This discoloration was a result of the resident hitting the metal bar of the Hoyer lift during transferring. The staff was educated on transferring the resident. The grievance stated that the DON was responsible for the investigation. The grievance stated it was resolved on 5/3/18 with a one to one discussion with the Resident's family by the DON. The	F 585	Immediate Action Resident #318 is no longer in the facility. Identification of others Effective 7/10/18 - 7/13/18the Director Of Social Work audit of all grievances for the last 90 will be reviewed to ensure that the facility has addressed and documented corrective for concerns outlined in the grievance. Systemic Changes Effective7/13/18, facility leadership team will be in-serviced on the grievance process including addressing and documentation of corrective actions outlined in the grievance. This education will be provided by Regional Clinical Consultant from for the management consulting company. Grievances will be addressed in daily stand up meeting Monday through Friday to ensure department heads are aware of grievances filed. This education will also be added to the new hire process. A copy of the education and the grievance log will be in a binder in the ED office. Monitoring Effective 7/13/18, the Executive Director will discuss grievances in daily stand up meeting Monday through Friday. The grievance log will be signed every week by the administrative team that is responsible for investigating and following through with grievances. Grievances will be monitored by the Executive Director. This monitoring will be conducted daily Monday through Friday x4 weeks, then weekly x 4weeks, then monthly thereafter. Findings will be reported in the monthly QAPI committee for 3 months for	

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	345529	A. BUILDING _____ B. WING _____	C 06/15/2018

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F 585	Continued From page 12 grievance did not address the resident's dry and flakey skin and the use of skin products. Another grievance dated 5/4/18 revealed that the resident's family had additional concerns of the resident's weight loss and the physician not updating her. The grievance was completed by the Speech therapist #1. The only information provided on the grievance stated that the Resident was added to speech therapy and that the Resident #318 was to work with speech therapy. No other information provided and the grievance stated that a one to one discussion was completed by the previous administrator. This grievance did not address or document concerns of how to contact the physician or address weight loss. Resident's #318 family was interviewed on 6/11/18 at 10:51 AM. She stated that she went to DON about feeding concerns and never got a response or a letter after her grievance was filed or for any of the grievances. She stated that around March, 2018 she put a grievance in the box in the main lobby requesting to meet with administration about the care of resident #318. She stated that she had concerns with the resident's eating and that the tray was just being left in the resident's room, dirty fingernails and that her family member would touch the food with her nails. She also stated that resident did have a swallow evaluation and the doctor never followed up the previous week. She stated that many of her concerns were never addressed and they never got back to her on things. The previous administration was interviewed on 6/13/18 at 12:10 PM. He stated that he was told that family wanted to meet with him. He stated that he tried for a week to meet with the family	F 585	recommendations and modifications until a pattern of compliance is achieved. REPONSIBLE PARTY Effective 7/13/18 the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	

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F 585	Continued From page 13	F 585		

and their biggest concern had to do with swallowing issues. He stated that speech was evaluating the resident. The family also had a concern with the bruises and it was obvious that the bruises was from the lift and the daughter was there for it (the explanation). He stated that the DON helped him to look into this. He stated that he did not recall anything about the family wanting to see the doctor and thought that the nutrition issue was related to the resident's swallowing, which she was seen for.

The speech therapist #1 stated on 6/13/18 at 11:27 AM that she had filed a grievance out for resident #318 and the family had a lot of concerns (the grievance was completed on 5/4/18 by the speech therapist). She stated that she gave the grievance to her supervisor. She said the family had concerns about the resident coughing and had some nursing issue.

The Social Worker was interview was interviewed on 6/13/18 at 11:16 AM. She stated that another staff member and herself had both completed grievances for this resident. One was about the resident's shampoo and that the resident was dirty. There was also a concern about the resident's weight loss and a grievance about bruising of the resident. She thinks there was 2 different grievances that she filled out. The grievance dated 4/16/18 was from the care plan meeting and there was a list of concerns and nursing staff investigated the concerns. She stated that she wrote up a grievance about the Hoyer lift too and the family wanted to know how the resident got the bruise. They did not know where the origin came from and gave the grievance to the DON. The end result revealed that the bruises were from the Hoyer lift. She

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F 585	Continued From page 14	F 585		

stated that she didn't investigated any of the grievance but just took it down. The administrator is responsible for the 1:1 meeting to address the grievance or a letter is sent by whoever investigated the grievance.

The DON was interviewed on 6/12/18 at 5:22 PM. The stated that a grievance was report on 4/16/18 and it was about that the shampoo bottle was used up very fast. He stated that he found out that the resident got showers twice a week and he talked to the NA's about it to make sure they only used this shampoo on this resident. He stated he also talked to the family about the resident losing weight and they gave her some supplements and medpass. He added that the resident was assisted with eating in the assisted living dining room and the staff fed her. He stated that there was discrepancy with the weight scale and now they have 2 trained people that weigh the resident. After they continued to monitor the resident weight, her weight stabilized. He stated that he had a discussion with the family on 4/20/18 in the patient's room. One day after they weighted the patients, he also discussed the concerns with the family and the family stated that they were ok without a written response. He stated that this grievance was from a care plan meeting. He stated that he also told the doctor that the family was want wanted to see him and they gave the family his number. He added that the resident's nails were not dirty when observed on the date of that grievance. He stated that he thought the family wanted to be notified of every little thing and he thought they were. He stated that after this grievance, the family did not come to him except when he saw the resident in hall and said "things are better" to him. He stated that when concerns were brought to him that he

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F 585	Continued From page 15 worked with families. The DON did provide any additional information on specific interventions that were taken to address the areas of snacks, dirty nails, and an ongoing cough, flakey skin and treatment, weight loss, contacting the physician for resident #318.	F 585		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to follow the abuse policy with the requirement to report abuse allegations within 2 hours of notification of the allegation. This was for 1 of 3 alleged abuse investigations completed by the facility. The finding included: The facility abuse policy: Policy was updated on November 2017. Reporting / Response: It is the policy of this facility that that "abuse" "allegations (abuse, neglect, exploitation or	F 607	F607 Root Cause Analysis of 1 of 3 the facility failed to follow the facility abuse policy with the requirement to report abuse allegation within 2 hours. The ED was notified timely of the allegation however her fax to the appropriate agencies was outside the two hour time frame. Immediate Action: Allegation was sent to the appropriate agency Identification of others affected: Effective 7/10/18-7/13/18 All abuse allegations in last 30 days were reviewed for timeliness of reporting. No other Initial Allegation reports were found to be out of	7/27/18

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F 607	Continued From page 16 mistreatment, including injuries of unknown source and misappropriation of resident property) are reported per Federal and State Law. The facility will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property , are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long term care facilities) in accordance with state law through established procedures. In addition, local law enforcement will be notified of any reasonable suspicion of a crime against a resident in the facility ... " Review of the abuse investigations since the last annual recertification revealed one investigation that was not reported according to the facility abuse policy. Revealed this "During an investigation of staff to resident abuse that was reported by an aide to the nurse on June 8, 2018 at 10:30am. "Resident told another Nursing Aide that a male with blue uniform, short braided hair, African American raped her a couple of weeks ago." Review of the report revealed the allegation was faxed to the state agency on June 8, 2018 at 2:19pm. Interview with the Administrator on June 15, 2018 at 1:05 pm revealed "her expectation per regulations was that all allegations of abuse be	F 607	compliance with reporting requirement. Systemic changes: Education will be provided to Executive Director and the leadership team by 7/13/18/ by the Regional Clinical Consultant from for the management consulting company regarding the importance of immediate notification of any alleged abuse, neglect, exploitation or mistreatment, injury of unknown source or misappropriation of property. Education included the requirement to complete notification via Initial Allegation Report to the State Survey Agency immediately but not later than 2 hours after the allegation is made. A log will be maintained by the Executive Director that documents all notifications to the State Survey Agency, including Resident name, fax cover sheet, confirmation page, allegation, date, time of discovery and time of notification. Log will be placed in binder maintained by Executive Director. Monitoring: The Executive Director will review log daily Monday through Friday for four weeks weekly for 4 weeks and monthly for 3 months to validate that all notifications to the State Survey Agency are timely. Findings will be reported to the QAPI Committee monthly for five months recommendations or modifications until a pattern of compliance is achieved. REPONSIBLE PARTY Effective 7/13/18 the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure	

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F 607	Continued From page 17 sent it within 2 hours of the allegation."	F 607	the facility remains in substantial compliance.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to report an abuse allegation within 2 hours of notification of the allegation. This was for	F 609	F609 Root Cause Analysis of 1 of 3 the facility failed to follow the facility abuse policy	7/27/18

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F 609	Continued From page 18 1 of 3 alleged abuse investigations completed by the facility. Finding included: Review of the abuse investigations since the last annual recertification revealed one investigation that was not reported within two hours after the abuse allegation was made. Revealed this "During an investigation of staff to resident abuse that was reported by an aide to the nurse on June 8, 2018 at 10:30am. "Resident told another Nursing Aide that a male with blue uniform, short braided hair, African American raped her a couple of weeks ago." Review of the report revealed the allegation was faxed to the state agency on June 8, 2018 at 2:19pm. Interview with the Administrator on June 15, 2018 at 1:05 pm revealed "her expectation per regulations was that all allegation of abuse be sent it within 2 hours of the allegation."	F 609	with the requirement to report abuse allegation within 2 hours. The ED was notified timely of the allegation however her fax to the appropriate agencies was outside the two hour time frame. Immediate Action: Allegation was sent to the appropriate agency Identification of others affected: Effective 7/10/18-7/13/18 All abuse allegations in last 30 days were reviewed for timeliness by the Regional Clinical Consultant from for the management consulting company of reporting. No other Initial Allegation reports were found to be out of compliance with reporting requirement. Systemic changes: Education will be provided to Executive Director and the leadership team by 7/13/18/ by the Regional Clinical Consultant from for the management consulting company regarding the importance of immediate notification of any alleged abuse, neglect, exploitation or mistreatment, injury of unknown source or misappropriation of property. Education included the requirement to complete notification via Initial Allegation Report to the State Survey Agency immediately but not later than 2 hours after the allegation is made. A log will be maintained by the Executive Director that documents all notifications to the State Survey Agency, including Resident name, fax cover sheet, confirmation page, allegation, date, time of discovery and time of notification. Log will be placed in binder maintained by Executive Director.	

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F 609	Continued From page 19	F 609	Monitoring: The Executive Director will review log daily Monday through Friday for four weeks weekly for 4 weeks and monthly for 3 months to validate that all notifications to the State Survey Agency are timely. Findings will be reported to the QAPI Committee monthly for five months recommendations or modifications until a pattern of compliance is achieved. REPONSIBLE PARTY Effective 7/13/18 the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the	F 640		7/23/18

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F 640	Continued From page 20 CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to transmit completed Minimum Data Set (MDS) assessments to the National Data Base (NDB) within the required 14 days for 3 of 5 residents reviewed for MDS assessment transmission. (Residents #3, #2 and #1). Findings included:	F 640	F640 Encoding/Transmitting Residents Assessments Based on the root cause analysis by the Clinical Reimbursement Coordinator and the facility Executive Director the MDS Nurse did not follow the RAI guidelines on transmitting the Minimum Data Set (MDS)	

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F 640	Continued From page 21 1. Resident #3 was admitted to the facility on 1/25/18 and discharged on 3/22/18. Record review revealed a discharge MDS dated 3/22/18 to be transmitted by 4/5/18. Record review revealed at the time of the survey the completed MDS had not been transmitted. Interview on 06/13/18 at 9:28 AM with the Clinical Reimbursement Coordinator (CRC) who stated the completed MDS for Resident # 3 was batched and ready to be submitted timely but did not happen. CRC stated the MDS coordinator must have missed a step to transmit. Continued interview with the CRC indicated the MDS for Resident #3 was transmitted on 6/12/18 at 5:20 PM. MDS coordinator #3 was unavailable for interview. Interview on 06/12/18 at 4:21 PM with the Administrator stated she expected the MDS to be transmitted per the regulations. 2. Resident #2 was admitted to the facility on 10/15/2012. Record review revealed a quarterly MDS dated 4/9/18 and to be transmitted by 4/26/18. Record review revealed at the time of the survey the completed MDS had not been transmitted. Interview on 06/13/18 at 9:28 AM with the Clinical Reimbursement Coordinator (CRC) who stated the completed MDS for Resident # 3 was batched and ready to be submitted timely but did not happen. CRC stated the MDS coordinator must have missed a step to transmit. Continued interview with the CRC indicated the MDS for Resident #3 was transmitted on 6/12/18 at 5:20 PM.	F 640	to the CMS system. Immediate Action: Assessments for residents # 3,#2, and #1 were submitted on 6/12/18 at 5:20pm. Identification of others affected: An audit transmission for the 90 days by the MDS nurse by 7-13-18. Any areas of non-compliance will be modified and re-submitted per RAI guidelines. Systemic changes: Education will be provided to the MDS nurses by 7/10/18/ by the Clinical Reimbursement Nurse timely transmitting of the MDS assessments to CMS System. This education by the Clinical Reimbursement Nurse will be kept in a binder in the Executive Director office. The Clinical Reimbursement Nurse will have a weekly phone call to review assessment completed to ensure timely transmission. Monitoring: Effective 7/13/18, the Clinical Reimbursement Nurse will audit all completed MDS assessments weekly for four weeks then a sample of assessments monthly for two months to ensure timely transmission to CMS. These audits will be kept in a binder in the Executive Directors office. Findings will be reported in the monthly QAPI committee for recommendations and modifications until a pattern of compliance is achieved. REPONSIBLE PARTY Effective 7/13/18 the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial	

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F 640	Continued From page 22 MDS coordinator #3 was unavailable for interview. Interview on 06/12/18 at 4:21 PM with the Administrator stated she expected the MDS to be transmitted per the regulations. 3. Review of the MDS transmission results summary form revealed a comprehensive MDS assessment dated 4/12/18 was completed and to be transmitted on 5/08/18 for Resident #1. Record review revealed at the time of the survey the completed MDS had not been transmitted. Interview on 06/13/18 at 9:28 AM with the Clinical Reimbursement Coordinator (CRC) who stated the completed MDS for Resident #1 was batched and ready to be submitted timely but did not happen. CRC stated the MDS coordinator must have missed a step to transmit. Continued interview with the CRC indicated the MDS for Resident #1 was transmitted on 6/12/18 at 5:20 PM. MDS coordinator #3 was unavailable for interview. Interview on 06/12/18 at 4:21 PM with the Administrator stated she expected the MDS to be transmitted per the regulations.	F 640	compliance.	
F 641 SS=E	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 review and staff interview the	F 641	F641 Accuracy of Assessments	7/23/18

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F 641	Continued From page 23 facility failed to accuracy code on the Minimum Data Set (MDS) assessment for 1 of 2 residents reviewed for behaviors (Resident #120), 1 of 7 residents reviewed for unnecessary medications. (Resident # 117), and 1 of 5 residents reviewed for pain management (Resident #105). Findings included: 1.Resident #120 was admitted on 2/27/18 from a recent hospitalization status post bacterial endocarditis and agitated delirium and discharged from the facility on 3/19/18. Review of the nursing progress notes revealed on 3/6/18 at 8:25 PM Resident#120 was non-compliant and uncooperative. Review of the social work progress notes revealed on 3/7/18 at 12:23 PM a care plan meeting was held via the phone. Concerns were raised by the family member regarding behaviors of refusing care, wandering into other resident rooms. Review of the nursing progress notes for 3/9/18 at 7:11 AM revealed Resident #120 refused blood sugar checks and to be weighed. Review of the nursing progress notes for 3/9/18 at 10:30 AM revealed Resident #120 was yelling and threatening the physical therapy staff. Review of the nursing progress notes for 3/10/18 at 6:49 PM revealed Resident #120 was combative and threatening to hit the staff. Review of the nursing progress notes for 3/11/18 at 7:41 AM revealed Resident #120 was aggressive and trying to go home. Review of the 14- day admission MDS dated 3/15/18 indicated zero (O) was coded for behavior symptoms despite the nursing and social work progress notes.	F 641	Root Cause: The facility failed to accurately code on the MDS resulting from an incomplete record review by the MDS team. Immediate Action Resident #120 has been discharged from the facility Resident # 117 Minimum data Set dated 5/30/18 was modified/corrected by MDS Nurse on 6/21/18 to indicate in Section N, question 0410, to include medication administered. Resident # 117 Minimum data Set dated 6/4/18 was modified/corrected by MDS Nurse on 6/15/18 to indicate in Section N, question 0410, to include medication administered. Identification of others affected: An audit of MDS assessments (sections E & N) for the last recent assessment will be completed by the MDS Nurses by 7/09/18 with the assistance of the Clinical Reimbursement Nurse to ensure accuracy of the assessments transmitted. Any assessments found to be incorrect will be corrected and resubmitted by 7/21/18. Systemic changes: Education will be provided to the MDS nurses by 7/10/18/ by the Clinical Reimbursement Nurse accuracy of the assessment. This education by the Clinical Reimbursement Nurse will be kept in a binder in the Executive Director office. Monitoring: Effective 7/21/18, the Clinical Reimbursement Nurse will audit a sample of completed MDS assessments weekly	

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F 641	Continued From page 24 Interview on 6/14/18 at 5:42 PM with the Director of Social Work revealed she missed the behavior coding on the MDS and should have read the progress notes. During an interview on 06/15/18 11:56 AM, with Nurse #3 who stated the resident had aggressive behavior toward staff and his Power of Attorney. Interview on 06/15/18 at 6:14 PM with the Chief Clinical Officer (CCO), clinical reimbursement coordinator and the Director of Nurses was held. The CCO stated the expectation was the MDS coordinator be accurate and to follow the follow the RAI (Resident Assessment Instrument. 2. Resident #117 was admitted to the facility on 5/23/18 and diagnoses included atrial fibrillation, congestive heart failure, depressive disorder and diabetes. An admission MDS dated 5/30/18 for Resident #117 identified she had received insulin and an antidepressant medication for 7 days of the look-back period and an antianxiety medication for 3 days of the look-back period. The MDS did not include the use of an anticoagulant medication. Review of the May 2018 medication administration record (MAR) for Resident #117 revealed she had received Eliquis (an anticoagulant) 5 milligrams (mg) twice daily from 5/23/18 through 5/25/18 and Aripiprazole (an antipsychotic) 2 mg daily from 5/23/18 through 5/31/18. The MAR did not identify that the resident had received any antianxiety	F 641	for four weeks then a sample of assessments monthly for two months to ensure coding accuracy. These audits will be kept in a binder in the Executive Directors office. Findings will be reported in the monthly QAPI committee for recommendations and modifications until a pattern of compliance is achieved. REPONSIBLE PARTY Effective 7/13/18 the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	

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F 641	Continued From page 25	F 641		

medications.

An interview with the MDS nurse on 6/15/18 at 2:35 pm revealed the MDS dated 5/30/18 for Resident #117 should have been coded for use of an antipsychotic medication for 7 days and for use of an anticoagulant for 3 days during the look back period. She stated the MDS should not have been coded for any antianxiety medications. She added this MDS would need to be corrected.

An interview with the Director of Nursing (DON) on 6/15/18 at 5:09 pm revealed it was his expectation that the MDS assessment be coded accurately to reflect the residents condition.

3. Resident #105 was admitted to the facility on 5/18/18 with diagnoses of acquired absence of left leg above the knee, chronic heart failure, obstructive and reflux uropathy, hyperlipidemia, pressure ulcer of left heel stage 3, sepsis, diabetes mellitus, and muscle weakness (generalized).

Resident #105's most recent MDS dated 6/4/18 was coded as a 14 day assessment. Resident #105 was coded with no cognitive impairment. The MDS coded active diagnoses as heart failure, diabetes mellitus, acquired absence of left leg above knee, chronic diastolic heart failure, obstructive and reflux uropathy, pressure ulcer left heel stage 3 pressure ulcer left heel stage 2, and chronic atrial fibrillation. Resident #105's MDS reported the resident has been on a scheduled pain medication regimen. A review of the MDS seven day look back reported Resident #105 had not had any opioid medications for the past 7 days.

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F 641	Continued From page 26 A review of Resident #105's MAR (Medication Administration Record) revealed the resident received Fentanyl 25mcg/hr patch on 5/28/18, 5/31/18, and 6/3/18. The MAR also revealed the resident received Oxycodone HCL 5 mg on 6/2/18. An interview was conducted with the MDS coordinator#2 on 6/15/18 at 3:00pm. She reported the MDS was coded incorrectly and that opioids were given in the 7 day look back period. It is her expectation that MDS assessments should be coded accurately. She will modify the MDS and resubmit.	F 641		
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.	F 655		7/23/18

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F 655	Continued From page 27 §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete the baseline care plan within 48 hours of admission and failed to review the baseline care plan with the resident, responsible party and/ or family for 6 of 6 new admissions (Resident #218, #422, #170, #93, #468 and #105). Findings Included: 1. Resident #218 was admitted to the facility on 6/01/18 and diagnoses included muscle weakness, heart failure, and dysphagia. Review of a baseline care plan dated 6/01/18 for Resident #218 revealed the following sections were noted to be blank: initial goals, summary of baseline care plan narrative, completion date,	F 655	F655 Baseline Care Plan Root Cause: The alleged noncompliance resulted from the facilities failure to complete the base line careplan within 48 hours of admission and review with the resident responsible and/or families. Immediate Action: Four or the six cited residents have a compehensive careplan and the other two have been discharged from the facility. Identification of others affected: Effective 7/10/18 - 7/13/18 Audit was performed on all admissions by MDS in the last 30 days for documented Baseline	

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F 655	Continued From page 28 and that it was not provided to the resident/resident representative. Review of the Admission Minimum Data Set (MDS) dated 6/08/18 for Resident #218 revealed that her cognition was intact. During an interview with Resident #218 on 6/13/18 at 5 pm, she stated she had no knowledge of the baseline care. During an interview on 6/14/18 at 1:14 pm, the MDS Nurse #1 stated the baseline care plans were started by the Admissions Director and then each discipline completed their section. She stated the goal was for the nurse on the hall to complete the sections and when completed the Admission Director would meet with the resident and / or the resident ' s responsible party within 72 hours of admission to review the baseline care plan with them. The MDS nurse #1 stated that during this meeting they were supposed to have the resident and /or responsible party sign the baseline care plan and give them a copy. She stated the Social Worker (SW) was one of the staff members designated to ensure that the baseline care plan was completed within 48 hours of admission and reviewed with the resident and / or responsible party and signed. During an interview on 6/14/18 at 3:10 pm, the Admission Director (AD) stated when a resident was admitted he would schedule the 72-hour baseline care plan meeting for the resident and / or family. The AD stated he or the SW would try and make arrangements to meet with the resident ' s family within 72 hours of admission. He stated he had not been providing the families with a copy of the baseline care plan or having them sign that they received it. During an interview on 6/14/18 at 3:15 pm, the SW stated a resident ' s baseline care plan was typically completed within 48 to 72 hours of	F 655	Care Plan. Any identified areas needing correcting were will addressed promptly. A copy of the audit will be kept in a binder in the Executive Directors office. Systemic changes: Education was provided to the Care Plan Team by the by the Clinical Reimbursement Nurse on 7/10/18. Baseline Care Plan form was reviewed and requirements that Baseline Care Plan be developed within 48 hours, reviewed and discussed with resident and their representative and copy given to them, after development. A log will be maintained by the MDS Coordinator that documents name and date of admission, date of baseline care plan development and date of meeting with resident and their representative with copy given to them. The log and copy of baseline care plan will be in the daily clinical stand-up meeting and maintained in binder in the MDS office with a copy to be kept in a binder in the Executive Directors office. Monitoring: The Lead MDS will review log and a copy of baseline care plan daily Monday through Friday for 2 weeks then weekly for 2 weeks and then monthly for 3 months. Findings will be reported to the QAPI Committee monthly for four months, recommendations or modifications until a pattern of compliance is achieved. REPONSIBLE PARTY Effective 7/13/18 the Administrator and Director of Nursing will be ultimately responsible to ensure	

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F 655	Continued From page 29 admission. She stated all disciplines participated in completion of the baseline care plan. The SW explained she was not getting the family to sign the baseline care plan. She added there was a place on the baseline care plan for the resident and / or family to sign that it had been reviewed with them, but the baseline care plan had never been signed by the family or resident. The SW confirmed the baseline care plan was not completed with Resident #218. The SW indicated that she was not aware that the baseline care plan needed to be signed by the resident or family until she was told today that it was her task. During an interview on 6/14/2018 at 3:45 pm the Director of Nursing (DON) stated it was his expectation that each department complete their section and the baseline care plan was signed and given to family according to the regulation. During an interview on 6/14/2018 at 4 pm, the Administrator revealed it was her expectation that baseline care plans were complete and reviewed with the resident and family member, per the regulation. 2. Resident #422 was admitted to the facility on 6/01/18 and diagnoses included, gastrostomy, hemiplegia, and dysphagia. Review of a baseline care plan dated 6/01/18 for Resident #422 was noted not to have information in sections which included history of falls and fall related injuries, bowel an bladder risk, alarms and restraints, resident's skin integrity goal, summary of baseline care plan narrative, completion date, and that it was not provided to the resident and/or resident representative. Review of the admission minimum data set (MDS) dated 6/08/18 for Resident #422 included he was moderately impaired. Resident #422 needed extensive assistance with his activities of daily living. Resident # 422 was being feed by	F 655	implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	

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tube.
During an interview with Resident #422 ' s representative on 6/13/18 at 5:30 pm revealed no knowledge of the baseline care.
During an interview on 6/14/18 at 1:14 pm, the MDS Nurse #1 stated the baseline care plans were started by the Admissions Director and then each discipline completed their section. She stated the goal was for the nurse on the hall to complete the sections and when completed the Admission Director would meet with the resident and / or the resident ' s responsible party within 72 hours of admission to review the baseline care plan with them. The MDS nurse #1 stated that during this meeting they were supposed to have the resident and /or responsible party sign the baseline care plan and give them a copy. She stated the Social Worker (SW) was one of the staff members designated to ensure that the baseline care plan was completed within 48 hours of admission and reviewed with the resident and / or responsible party and signed.
During an interview on 6/14/18 at 3:10 pm, the Admission Director (AD) stated when a resident was admitted he would schedule the 72-hour baseline care plan meeting for the resident and / or family. The AD stated he or the SW would try and make arrangements to meet with the resident ' s family within 72 hours of admission. He stated he had not been providing the families with a copy of the baseline care plan or having them sign that they received it.
During an interview on 6/14/18 at 3:15 pm, the SW stated a resident ' s baseline care plan was typically completed within 48 to 72 hours of admission. She stated all disciplines participated in completion of the baseline care plan. The SW explained she was not getting the family to sign the baseline care plan. She added there was a

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place on the baseline care plan for the resident and / or family to sign that it had been reviewed with them, but the baseline care plan had never been signed by the family or resident. The SW confirmed the baseline care plan was not completed with Resident #218. The SW indicated that she was not aware that the baseline care plan needed to be signed by the resident or family until she was told today that it was her task.
During an interview on 6/14/2018 at 3:45 pm the Director of Nursing (DON) stated it was his expectation that each department complete their section and the baseline care plan was signed and given to family according to the regulation.
During an interview on 6/14/2018 at 4 pm, the Administrator revealed it was her expectation that baseline care plans were complete and reviewed with the resident and family member, per the regulation.
3. Resident #170 was admitted to the facility on 5/23/18 with cumulative diagnoses which included chronic diastolic CHF, diabetes, depression, gout and end stage renal disease requiring hemodialysis three times a week.
Review of the admission physician orders included:
" ASA 81milligrams (mg) by mouth (po) as preventative measure to reduce a stroke.
" Fluoxetine 40 mg po daily for the treatment of depression.
" Glimepiride 1 mg po every morning for management of blood sugars.
" MVI/Minerals 1 every morning as a nutritional supplement.
" Sodium phosphate 250 mg po daily to relieve constipation.
" Uloric 40 mg daily po to treat gout.
" Vitamin B12 1,000 mcg (micrograms) daily po a supplement

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" Amitriptyline 19 mg po at bedtime for depression
" Fluticasone 1 spray via nostrils to reduce nasal inflammation.
" Combivent inhalant 1 puff three times a day as a bronchodilator
" Aranesp 60 mcg/ml (milliliter). Inject 1ml every 7 days with dialysis that helps the body produce red blood cells.
" Flomax 0.8 mg po three times a day for urine retention.
" Hemodialysis every Monday, Wednesday and Friday.
" 1500 cc fluid restriction.
" Liberal renal, controlled concentrated sweets diet.
" Check left upper arm for bleeding, bruising and the bruit and thrill each shift.

Record review revealed a baseline care plan dated 5/23/18 at 3:30 PM. There was a signature and date of 5/23/18 by the author of the baseline care plan but none by Resident #170. Under section for "outside coordination" the provider address and name were not noted. There was no notation about the care of the shunt nor the assessment of the shunt (checking the thrill, bruit, bruising and bleeding). Continued review revealed no initial goals and interventions established to address his medications, treatments, diet and initial needs.

Record review revealed at the time of the survey on 6/13/18 revealed there was no comprehensive care plan (CCP) developed. Continued review revealed the CCP was developed on 6/14/18.

Interview on 06/14/18 07:58 AM with Resident #170 who stated "the only discussion and plan

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that was provided to me was when my rehab (rehabilitation) goals and plans were discussed."

During an interview on 6/14/18 at 1:14 pm, the MDS Nurse #1 stated the baseline care plans were started by the Admissions Director and then each discipline completed their section. She stated the goal was for the nurse on the hall to complete the sections and when completed the Admission Director would meet with the resident and / or the resident's responsible party within 72 hours of admission to review the baseline care plan with them. The MDS nurse #1 stated that during this meeting they were supposed to have the resident and /or responsible party sign the baseline care plan and give them a copy. She stated the Social Worker (SW) was one of the staff members designated to ensure that the baseline care plan was completed within 48 hours of admission and reviewed with the resident and / or responsible party and signed.

During an interview on 6/14/18 at 3:10 pm, the Admission Director (AD) stated when a resident was admitted he would schedule the 72-hour baseline care plan meeting for the resident and / or family. The AD stated he or the SW would try and make arrangements to meet with the resident's family within 72 hours of admission. He stated he had not been providing the families with a copy of the baseline care plan or having them sign that they received it.

During an interview on 6/14/18 at 3:15 pm, the SW stated a resident's baseline care plan was typically completed within 48 to 72 hours of admission. She stated all disciplines participated in completion of the baseline care plan. The SW explained she was not getting the family to sign

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the baseline care plan. She added there was a place on the baseline care plan for the resident and / or family to sign that it had been reviewed with them, but the baseline care plan had never been signed by the family or resident. The SW confirmed the baseline care plan was not completed. The SW indicated that she was not aware that the baseline care plan needed to be signed by the resident or family until she was told today that it was her task.

During an interview on 6/14/2018 at 3:45 pm the Director of Nursing (DON) stated it was his expectation that each department complete their section and the baseline care plan was signed and given to family according to the regulation.

During an interview on 6/14/2018 at 4 pm, the Administrator revealed it was her expectation that baseline care plans were complete and reviewed with the resident and family member, per the regulation.

The author of the resident's baseline care plan was not available for interview.

4. Resident #93 was readmitted to the facility on 5/17/18 with cumulative diagnoses which included status post abscess with perforation of the surgical incision, gastrostomy tube (GT), breast cancer, failure to thrive and long-term coagulant therapy.
Review of the admission physician orders dated 5/17/18 included:
" Anastrozole 1 milligrams (mg) 1 tablet once daily by mouth (po) for breast cancer.
" Lorazepam 1 mg po at bedtime for anxiety.
" Eliquis 2.5 mg by mouth 2 times a day for coagulant therapy in the treatment of atrial

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fibrillation.
" Norco 5-325 every four hours po as needed for pain.
" Cardizem 30 mg po every 6 hours for hypertension.
" Colostomy care. Change pouch when leaking and every 5-7 days.
" Negative wound therapy with vacuum therapy -125 mmHg. Change Monday, Wednesdays and Fridays
" Care of the GT.
" Mechanical diet

Review of the resident's undated baseline care plan revealed no summary, goals, care, services or interventions that addressed an unhealed surgical and abscess site, use of a wound vacuum for healing, chemotherapy, colostomy care, nutritional needs by mouth or through a GT, care of a GT and prescribed medications. Record review revealed a comprehensive care plan had not been developed within 48 hours of admission.

During an interview on 6/14/18 at 1:14 pm, the MDS Nurse #1 stated the baseline care plans were started by the Admissions Director and then each discipline completed their section. She stated the goal was for the nurse on the hall to complete the sections and when completed the Admission Director would meet with the resident and / or the resident's responsible party within 72 hours of admission to review the baseline care plan with them. The MDS nurse #1 stated that during this meeting they were supposed to have the resident and /or responsible party sign the baseline care plan and give them a copy. She stated the Social Worker (SW) was one of the staff members designated to ensure that the baseline care plan was completed within 48 hours

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of admission and reviewed with the resident and / or responsible party and signed.

During an interview on 6/14/18 at 3:10 pm, the Admission Director (AD) stated when a resident was admitted he would schedule the 72-hour baseline care plan meeting for the resident and / or family. The AD stated he or the SW would try and make arrangements to meet with the resident's family within 72 hours of admission. He stated he had not been providing the families with a copy of the baseline care plan or having them sign that they received it.

During an interview on 6/14/18 at 3:15 pm, the SW stated a resident's baseline care plan was typically completed within 48 to 72 hours of admission. She stated all disciplines participated in completion of the baseline care plan. The SW explained she was not getting the family to sign the baseline care plan. She added there was a place on the baseline care plan for the resident and / or family to sign that it had been reviewed with them, but the baseline care plan had never been signed by the family or resident. The SW confirmed the baseline care plan was not completed. The SW indicated that she was not aware that the baseline care plan needed to be signed by the resident or family until she was told today that it was her task.

During an interview on 6/14/2018 at 3:45 pm the Director of Nursing (DON) stated it was his expectation that each department complete their section and the baseline care plan was signed and given to family according to the regulation.

During an interview on 6/14/2018 at 4 pm, the Administrator revealed it was her expectation that

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baseline care plans were complete and reviewed with the resident and family member, per the regulation.

Interview on 06/15/18 12:30 PM with Resident #93 revealed she could not recall whether a baseline care plan or any care plan was explained to her.

5. Resident #468 was admitted to the facility on 6-1-18 with multiple diagnoses that included osteomyelitis, heart failure, chronic kidney disease and chronic obstructive pulmonary disease.

The 5-day Minimum Data Set (MDS) dated 6-8-18 revealed that Resident #468 was cognitively intact.

Resident #468's baseline care plan was noted not to have a date and did not have any initial goals, written summary or that it was provided to the resident.

During an interview with Resident #468 on 6-14-18 at 11:00am she stated she was unaware that she had a care plan. The resident stated that no one had spoken to her or provided her a summary of her care plan and that her goals were not discussed with her other than she would be receiving physical and occupational therapy.

The corporate manager was interviewed on 6-14-18 at 5:00pm who stated that care plans were only located in the paper chart and that he was aware that there was an issue with the care plans.

An interview with the Administrator occurred on

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6-14-18 at 6:15pm who stated her expectation would be that staff would follow the regulations and make sure each resident was informed of their care plan.

6. Resident #105 was readmitted to the facility on 5/18/18 with diagnoses of acquired absence of left leg above the knee, chronic heart failure, obstructive and reflux uropathy, hyperlipidemia, pressure ulcer of left heel stage 3, sepsis, diabetes mellitus, and muscle weakness (generalized).
Resident #105's most recent MDS dated 6/4/18 was coded as a 14-day assessment. Resident #105 was coded with no cognitive impairment. The MDS coded active diagnoses as heart failure, diabetes mellitus, acquired absence of left leg above knee, chronic diastolic heart failure, obstructive and reflux uropathy, pressure ulcer left heel stage 3 pressure ulcer left heel stage 2, and chronic atrial fibrillation. Resident #105's MDS reported the resident has been on a scheduled pain medication regimen. A review of the MDS seven day look back reported Resident #105 had not had any opioid medications for the past 7 days. Resident's functional status on the MDS was coded as the resident needed 2+ persons for physical assistance with transfers, bed mobility, and one person assist with toileting.
A review of Resident #105's base line care plan dated 5/18/18 revealed pain management was not addressed in the care plan. The care plan revealed stand by assistance for ambulation and transfers.
A review of Resident #105's medical records reveal an admission nursing note dated 5/18/18 which reported that the resident needed two person assistance with mechanical lift to transfer resident.

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F 655	Continued From page 39 An interview was conducted with the MDS coordinator #2 on 6/15/18 at 3:10pm. She reported every resident is required to have a baseline care plan completed within 48 hours of admission which should address every area of concern for each resident. She reported Resident #105's baseline care plan was inaccurate and not complete.	F 655		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights 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	F 656		7/23/18

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F 656	Continued From page 40 resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, observations and resident and staff interviews, the facility failed develop a care plan for pain management for 2 of 3 residents reviewed for pain management (Resident #22, Resident 105). The facility failed to develop a care plan for the use of an anticoagulant medication for 1 of 7 residents reviewed for unnecessary medications (Resident #117). The facility failed to develop a care plan for 1 out of 5 residents (Resident # 105) reviewed for accidents. The facility failed to develop a care plan for 1 out of 2 residents (Resident #41) reviewed for edema. Findings include: 1. Resident #22 was admitted to the facility on 10/12/15 with the diagnosis of muscle weakness, and posture abnormality. A note from physical therapy dated 3/13/18 revealed that the resident was noted to have increasing left knee contraction and needed maximum assistance with transfers.	F 656	F656 Development/Implement Comprehensive Care Plan Root Cause: The alleged noncompliance resulted from the facilities failure to develop careplan in the areas of pain management, anticoagulant medication and edema. Immediate Action: The Care Plan for resident #22 and resident #105 was reviewed and updated to include issues related to pain management on 7-3-18 by IDT Team. The care plan for resident #117 was reviewed and updated to include use of all medications. The care plan for resident #105 was reviewed and updated to include issues related to accidents. The care plan for resident #41 was reviewed and updated to include issues related to edema. Identification of others affected: The care plan team (consisting of the Social Worker, MDS Nurse, Dietary	

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F 656	Continued From page 41 The resident's annual Minimum Data Set dated 3/28/18 revealed the resident was cognitively intact. No moods or behaviors were noted. The resident required extensive assistance with bed mobility, transfers, locomotion, and dressing. The resident required limited assistance with locomotion and eating. The resident required physical help in bathing. The resident had been on scheduled pain regimen and no pain was present. Resident #22 had a care plan in place for pressure ulcers and Activities of Daily Living (updated 4/5/18). There were no care plans in place for pain management or interventions that addressed the resident's pain. Review if the resident's Medication Administration Records revealed the resident had an order for Acetaminophen (a medication for pain) as needed for pain and last received Acetaminophen on 6/11/18 at 6:00 AM. The resident also had orders for tramadol every 6 hours as needed for pain (ordered 5/12/18). The patient last received the Tramadol pain medication on 5/12/18, 5/13/18, 5/14/18, and 5/23/18. Nurse #3 asked the resident if she was having pain on 5/11/18 at 8:49 AM and the resident stated that her "butt hurts". Nurse #3 stated that she could give the resident some pain medication for it. The resident stated that "it just hurts, I'll put it like that." The resident also stated that right now her pain was on her butt and she could feel it. The resident then stated "no" when asked if she wanted medication for the pain right now. Nurse #3 was interviewed on 6/11/18 at 2:35 PM. She stated that the resident had pain sometimes	F 656	Manager and Activity Director) met and reviewed/updated all resident care plans on 7-3-18 for residents currently residing in facility, utilizing most recent Comprehensive Assessment and other chart information. Systemic changes: Education was provided to the Care Plan Team by the Clinical Reimbursement Nurse, which included development of comprehensive on 7/10/18. Updated care plans were placed in each resident's chart. Care Plans will be reviewed and updated following the RAI Guidelines going forward and updates will be documented on care plans as issues occur. Monitoring: The Lead MDS will review a sample of care plans on weekly basis for 4 weeks and then monthly for 3 months. Findings will be reported to the QAPI Committee monthly for recommendations or modifications until a pattern of compliance is achieved. REPONSIBLE PARTY Effective 7/13/18 the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	

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and had scheduled pain medication. She stated that the resident would tell her when she was having pain and sometimes would take pain medications and other times, she will not. She stated that she would assess the resident's pain every shift and as needed.

The MDS nurse#2 was interviewed on 6/12/18 at 4:45 PM. She stated that the care plan is based off the comprehensive assessment which is based off the nursing notes, medications, any falls or incidents or social work concerns. Then the triggers would come off the annual or admission assessment. The MDS nurse #2 stated that 3/28/18 was the resident's last annual MDS assessment and resident #22 triggered for ADL'S, urinary incontinence, falls, dehydration, pressure ulcers, and nutritional status. The resident was care planned for pressure ulcers, falls, do not resuscitate, allergies, fluid deficient, socialization needs and aphasia. She stated that the last care plan was updated on 4/12/18 and that she would be the one to initiate care plans. She stated that the resident had not complained of pain to her when she spoke to her. She stated that there was no care plan for pain and it was not triggered in her yearly assessment as the resident did not complain of pain. She stated that on 6/7/18, the resident had a complaint of pain per the nursing note. She stated that during clinical rounds they would update the resident care plans if needed. If the resident was given as needed medication for pain then it should be monitored during clinical rounds.

The Administrator was interviewed on 6/13/18 at 2:26 PM. She stated that the care plans should be reflected of the patients.

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2. Resident #117 was admitted to the facility on 5/23/18 and diagnoses included atrial fibrillation, congestive heart failure, depressive disorder and diabetes.

Review of the physician ' s orders dated 5/23/18 for Resident #117 revealed an order for Eliquis (an anticoagulant) 5 milligrams (mg) twice daily for atrial fibrillation.

Review of a physician ' s order dated 5/25/18 for Resident #117 revealed an order to discontinue the Eliquis.

An admission minimum data set (MDS) dated 5/30/18 for Resident #117 did not identify the use of an anticoagulant medication.

Review of a physician ' s order dated 6/8/18 for Resident #117 revealed an order to start Eliquis 5 mg twice daily.

Review of the care plans for Resident #117 revealed the last care plan update had been 5/30/18 and did not include a care plan for the use of an anticoagulant.

An interview with the MDS nurse #2 on 6/15/18 at 2:35 pm revealed Resident #117 should have had a care plan for the use of an anticoagulant.

An interview with the Director of Nursing (DON) on 6/15/18 at 5:09 pm revealed it was his expectation that residents receiving anticoagulants have an appropriate care plan in place.

3. Resident #105 was readmitted to the facility on 5/18/18 with diagnoses of acquired absence of

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left leg above the knee, chronic heart failure, obstructive and reflux uropathy, hyperlipidemia, pressure ulcer of left heel stage 3, sepsis, diabetes mellitus, and muscle weakness (generalized).
Resident #105's most recent MDS dated 6/4/18 was coded as a 14-day assessment. Resident #105 was coded with no cognitive impairment. The MDS coded active diagnoses as heart failure, diabetes mellitus, acquired absence of left leg above knee, chronic diastolic heart failure, obstructive and reflux uropathy, pressure ulcer left heel stage 3 pressure ulcer left heel stage 2, and chronic atrial fibrillation. Resident #105's MDS reported the resident has been on a scheduled pain medication regimen. A review of the MDS seven day look back reported Resident #105 had not had any opioid medications for the past 7 days. Resident's functional status on the MDS was coded as the resident needed 2+ persons for physical assistance with transfers, bed mobility, and one person assist with toileting.
A review of Resident #105's care plan dated 5/18/18 revealed pain management was not addressed in the care plan. The care plan revealed stand by assistance for ambulation and transfers.
A review of Resident #105's medical records reveal an admission nursing note dated 5/18/18 which reported that the resident needed two person assistance with mechanical lift to transfer resident.

4. Resident #41 was admitted to the facility on 8/14/14 with diagnoses that included atherosclerotic heart disease of native coronary artery without angina pectoris, diabetes mellitus, abnormal posture, primary generalized arthritis, Alzheimer's disease, gastroesophageal reflux

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F 656	Continued From page 45 disease, history of falls, polyosteoarthritis, dementia, and major depressive disorder. A review of Resident #41's MDS dated 4/21/18 was coded as an annual assessment. Resident #41 was coded as mildly cognitively impaired. Active diagnoses were coded as heart failure, hypertension, obstructive uropathy, diabetes mellitus, hyperlipidemia, Alzheimer's disease, abnormal posture, atherosclerotic heart disease, muscle weakness, constipation, and unspecified glaucoma. The MDS coded the resident as receiving a diuretic medication for 7 out of 7 days during the assessment look back period. A review of Resident #41's medical record revealed a physician's order dated 1/16/18 for Lasix 40mg twice daily for edema and for the facility to weigh the resident weekly. A review of Resident #41's care plan revealed the resident's edema was not addressed on the care plan. An interview with the MDS coordinator#2 was conducted on 6/15/13 at 3:10pm. She reported Resident #105's care plan was not completed to address pain management and did not correctly address ADL activities. She revealed Resident #41's care plan did not address edema. She reported that she expects all care plans to address each resident's individual needs. She stated she will update the care plans to reflect pain management and correct ADL care.	F 656		
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	F 677		7/23/18

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F 677	Continued From page 46 by: Based on record review, observation and staff interviews the facility failed to provide activities of daily living for 2 of 9 residents (Resident #20 and Resident #22) by not rinsing soap off the residents and wash a resident's back when giving a bath for 1 of 9 residents reviewed for ADL (Resident #22). Findings included: 1. Resident #20 was admitted to the facility on 4-25-08 with multiple diagnoses which included atrial fibrillation, contracture of the left hand, adult failure to thrive and chronic obstructive pulmonary disease. The quarterly Minimum Data Set (MDS) dated 4-3-18 revealed the resident was severely cognitively impaired and needed extensive assistance with 2 people for personal hygiene and physical help with one person for bathing. Resident #20's care plan dated 8-22-17 revealed a goal that the resident would be clean and dry and minimize risk for skin break down and urinary tract infection. The following were the interventions; observe skin daily, weekly skin assessments, reposition, provide incontinence care every 2-3 hours, anticipate and meet needs for activities of daily living (ADL) care. During an observation of ADL care with NA #3 on 6-13-18 at 11:05am revealed NA #3 squirting soap into a basin of warm water and stirring the water with a wash cloth until it became bubbly. It was noted that the directions on the soap bottle were; wet skin or wash cloth, apply soap, wash area then rinse well. NA #3 was noted not to rinse	F 677	F 677 ADL Care Provided for Dependent Residents Root Cause Analysis Based on the root cause analysis by the facility administrative staff and the facility Executive Director the facility did not follow the manufactures recommendation when using the facilities shampoo and body wash when providing ADL care for a dependent resident. Manufactures recommendation is to rinse shampoo and body wash off after application. Immediate Actions The Director of Nursing / Assistant Director of Nursing will inservice for all Certified Nursing Assistants on the manufactures recommendations on rinsing after the application of body wash. This inservice will be completed by 7-13-18 and any staff not educated will not be allowed to work until education is completed. This education will be added to the new hire process for new CNA's. A copy of the inservice will be kept in a binder in the Executive Directors office. Identification of others Residents requiring assistance with bed baths are at risk for the deficient practice therefore the facility will provide education on the manufactures recommendations when using the shampoo and body wash. Systemic Changes By 7/13/2018 100% of nursing staff was in-serviced bathing for any resident needing assistance. The education was provided by the Director of nursing/ Assistant Director of Nursing, any staff not educated will not be allowed to work until	

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F 677	Continued From page 47 the soap from Resident #20 after washing. Resident #20 was interviewed on 6-13-18 at 11:15am who stated she was "ok" with the care she was provided. The resident did state she had some itching after her bath "sometimes if they don't use lotion." An interview with NA #3 occurred on 6-13-18 at 11:20am. NA #3 stated she was aware that she was supposed to rinse the soap off the resident but "the residents are charged for their basins so they only have one basin and I cannot rinse the soap off with only one basin." The NA also stated that leaving soap on the resident's skin could cause skin breakdown. During an interview with the Administrator on 6-14-18 at 6:15pm she stated she expected her staff to rinse the soap off residents once they were done washing the area. 2. Resident #22 was admitted to the facility on 10/12/15 with the diagnosis of muscle weakness, hypertension, and posture abnormality. Resident #22 had a care plan in place created 3/31/17 for scheduled care tasks. An intervention included that the resident would receive a bath. Review of the annual Minimum Data Set (MDS) dated 3/28/17 revealed Resident #22 was cognitively intact. The resident had no behaviors or rejection of care noted. The resident required extensive assistance with bed mobility with 1-person assistance. The resident required physical help in bathing with 1-person assistance.	F 677	education is completed. This education will be added to the new hire process for new nursing staff. Monitoring Effective 7/13/18 the Administrative Nursing Team will observe bed baths for 5 residents daily (Monday – Friday) for 2 weeks then 5 bed baths a week for four weeks then 5 bed baths a month for 3 months. The results from this observation will be documented on the daily clinical rounds report form and filed in a binder in the Director of Nursing office and reviewed during the daily clinical stand-up meeting. If any CNA is identified to be incorrectly providing care the administrative nurses will follow up with the assigned staff to ensure care is provided following manufacturing recommendations. Findings will be reported in the monthly QAPI committee for recommendations or modifications until a pattern of compliance is achieved. REPONSIBLE PARTY Effective 7/13/18 the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	

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The direction of use (online, no date) for the tearless hair and body wash states to "dispense a small amount of product onto wet washcloth or hand, work into a rich lather, rinse and repeat if necessary."
The resident was attempted to be interviewed on 6/12/18 at 8:46 AM. The resident was unable to answer detailed questions or be interviewed.

The Nursing Assistant (NA) #5 was observed giving Resident #22 a bed bath on 6/13/18 at 6:53 AM. A basin with soapy water was observed on the resident's bedside table. The resident's face and chest were washed with the soapy water, were not rinsed, and were patted dry with a cloth. Then the soapy water was exchanged for more soapy water and the resident's abdomen, stomach, legs and perineal area were washed, not rinsed and then patted dry. The soapy water was then exchanged for more soapy water and the resident was turned on her left side. The resident's buttock was washed with the soapy water, was not rinsed and dried with a towel. The resident's back was never washed. Lotion was then applied to the resident's chest, hands, legs and feet. The resident's clothes were put on and Resident #22 was transferred with assistance to the wheelchair.

The NA #5 was interviewed on 6/13/18 at 9:40 AM. She stated that she forgot to wash the resident's back and she did not rinse the soap off because she thought it was the no rinse wash. NA #5 retrieved the tearless hair and body wash from Resident #22's bathroom on 6/13/18 at 2:18 PM. NA #5 confirmed this was the body washed used on the resident. The back of the body wash label stated to "Rinse Well".

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F 677	Continued From page 49 The Director or Nursing was interviewed on 6/13/18 at 2:40 PM. He stated that he would expect if the body wash needed to be rinsed off of the resident then the nursing assistants should follow the instructions on the bottle.	F 677		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review, observation, physician and staff interviews the facility failed to monitor the administration of tube feeding formula and water flushes as ordered by the physician for a resident that experienced a significant weight loss and dehydration. This was evident for 1 of 7 residents that was reviewed for nutrition	F 692	F692 Nutrition/Hydration Status Maintenance Root Cause Analysis Based on the root cause analysis by the facility Administrative staff and the facility executive director the facility did not follow policy and procedure by failing to ensure	7/23/18

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F 692	Continued From page 50 (Resident #422). Findings Included: Resident #422 was admitted to the facility on 2/23/18 and diagnoses included dysphagia with gastrostomy tube, congestive heart failure, diabetes, hypertension and aphasia. Review of physician ' s orders dated 2/23/18 for Resident #422 revealed an order for a brand name tube feeding formula that provided 1.2 calories per milliliter (ml) at 80 ml per hour via the gastrostomy tube (g-tube), a water flush of 100 ml every 4 hours via the g-tube and an order to be NPO (nothing by mouth). Review of a nutrition note completed by the Registered Dietitian (RD) dated 2/27/18 for Resident #422 stated diet was brand name tube feeding formula that provided 1.2 calories per ml at 80 ml per hour. NPO due to silent aspiration. Height was 72 inches and weight was 147 lbs. (hospital weight). Ideal body weight (IBW) range 172 lbs. to 182 lbs. and body mass index (BMI) was 19.8. Resident at 84% of his IBW. Estimated nutritional needs based on weight of 154 lbs. were 1747 to 2070 calories, 62 to 69 grams of protein and 1747 to 2070 ccs of fluid. Tube feeding provided 1920 ml, 2034 calories, 115 grams of protein, 1555 ml free water. Nutritional needs were being met with current tube feeding order. Recommended 150 ml free water flush every 6 hours to provide a total of 2155 ml water. Continue to monitor weight, skin and labs for further recommendations. An admission minimum data set (MDS) for Resident #422 dated 3/2/18 identified he had a	F 692	tube feeding orders were on the resident medication administration record (MAR) ensuring the documentation of actual nutrition and not implementing additional monitoring when resident behaviors prevented him from receiving tube feeding per the physician orders to prevent significant weight loss and dehydration. Immediate Action On 6/7/18 resident #422 diet was changed to mechanical soft low concentrated sweet with nectar thick liquids with meals and thin water between meals. Identification of Others All residents requiring a gastrostomy tube are at risk for the deficient practice therefore a 100 percent audit will be completed by the registered dietician by 7/11/18 each resident requiring a tube for nutrition and medication administration. This audit will include nutritional needs, weights and the need for any labs. Systemic Changes Effective 7/9/18 The Dietary Manager will review weekly and monthly weights to identify any residents with significant weight loss. The dietary manager will place those residents identified on the weekly standards of care list to be reviewed by the IDT during the weekly standards of care meeting to discuss interventions to put in place. The residents will be placed on the Dietitian's list to review during her next visit. Nurse management will notify the Physician/ Nurse Practitioner to inform of weight loss and get approval for any suggested interventions. On 7/11/18 the Dietary Manager was	

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F 692	Continued From page 51 feeding tube that provided 51% or more of his total daily caloric intake and provided an average daily fluid intake of 501 cc ' s or more. His height was 72 inches, weight was 143 pounds (lbs.) and his cognition was moderately impaired. The MDS did not identify any behaviors related to rejection of care. A care plan dated 3/2/18 for Resident #422 stated he was at risk for complications related to feeding tube. Interventions included to keep head of bed elevated, to administer tube feeding and water flushes per physician orders, to document intake and output, notify physician as needed, weigh resident per facility protocol, RD to review dietary regimen, check placement and residual per facility protocol and observe for any complications such as aspiration, weight loss, nausea/vomiting, etc. A care plan dated 3/2/18 for Resident #422 stated he was at risk for dehydration related to g-tube. The goal was he would have no signs / symptoms of dehydration. Interventions included to obtain lab works as ordered, weigh per facility protocol, observe for signs / symptoms of dehydration, notify physician as needed and administer tube feeding and water flushes per order. Review of the February 2018 medication administration record (MAR) for Resident #422 revealed an order to flush the g-tube with 100 ccs of water every 4 hours. The start date was 2/23/18 and discontinue date was 3/6/18. The water flush was signed off with a check mark as being administered at 5:00 am, 9:00 am, 1:00 pm, 5:00 pm and 9:00 pm from 2/23/18 through 2/28/18. There was no order on the February 2018 MAR to administer the tube feeding	F 692	in-serviced by the registered dietician to report any residents identified with significant loss to the Dietitian, executive director, and Nurse management weekly/monthly to ensure interventions are put in place to prevent future weight loss or to maintain weight. Each resident identified must be placed on the weekly standards of care meeting list and the Dietitian list for review. Beginning 7/9/18 and to be completed by 7/13/18 100% of nursing staff was in-serviced to report a decline in residents' intake or the ability to feed self or any weight changes to nursing administration as soon as identified. Licensed nurses will also be educated on ensuring tube feeding orders are on the MAR monthly to allow for documentation of tube feeding. Licensed staff will place on 24 hour report sheet. Nursing administration will review 24 hour report sheet daily during clinical rounds. This education was provided by the Director of Nursing/ Assistant Director of Nursing, any staff not educated will not be allowed to work until educated. This education will also be added to the new hire process. Monitoring Effective 7/13/18 The Dietary manager will monitor weekly /monthly weights to identify residents with significant weight loss and verify an intervention is put in place. The Registered Dietician will monitor / assess all tube feeders monthly for four months to ensure all nutritional needs are being met. The Director of Nursing/ Assistant Director of Nursing / Unit Manager will review the 24 hour	

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F 692	Continued From page 52 formula. Review of the March 2018 MAR for Resident #422 revealed an order to flush the g-tube with 150 ml water every 6 hours with a start date of 3/1/18 and a discontinue date of 3/26/18. The water flush was signed off with a check mark as being administered at 12:00 am, 6:00 am, 12:00 pm and 6:00 pm from 3/1/18 through 3/26/18 with two entries that resident refused. The March 2018 MAR revealed an order for brand name tube feeding formula that provided 1.2 calories per ml, give 480 ml per g-tube at 8:00 am, 12:00 pm and 9:00 pm. The order had a start date of 3/31/18 and was initialed with a check mark as being administered once on 3/31/18 at 9:00 pm. There was no order on the March 2018 MAR to administer tube feeding formula from 3/1/18 through 3/30/18. Review of a nursing note entry on 3/12/18 for Resident #422 stated resident would not let this writer give him his medications or flush his g-tube. Review of a nursing note entry dated 3/18/18 for Resident #422 stated resident with abdominal binder on at all times, still noted to take feeding out of g-tube and let it run onto the floor. Review of a nursing note entry dated 3/22/18 for Resident #422 stated resident refused 3 times for this writer to give him medications in his g-tube and refused tube feeding at this time. He used his left hand to push this writers hand away and shook head "no". Earlier this shift resident took feeding tube out of his g-tube and hung it on the pole and let the feeding run out on the floor. Resident has been off the tube feeding for	F 692	report to identify any residents with poor intake, decrease in the ability to feed self and weight changes during daily clinical meeting 5 days per week (Monday – Friday). This Monitoring will be continued by the Charge nurses on Saturdays and Sundays. This monitoring will be conducted daily x 4 weeks, then 3 days a week for 4 weeks, then weekly for 4 weeks then monthly for 3 months. Findings will be reported monthly to the QAPI committee for recommendations or modifications until a pattern of compliance is achieved. REPONSIBLE PARTY Effective 7/13/18 the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	

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approximately two hours as this point and still refused to let this writer reapply feeding. New feeding container and fresh water hung and ready for insertion into g-tube.

Review of a RD note dated 3/25/18 for Resident #422 stated he was NPO and received a brand name tube feeding formula that provided 1.2 calories per ml at 80 ml an hour and 100 ml water flush every 4 hours. Weight was 137.2 lbs. (3/25/28). Nursing staff reported the resident would push the call button if he was full and if they didn ' t turn off the feeding pump he would disconnect the tube feeding and let it run on the floor. The nurse informed me they would let the feeding pump stay off for several hours before turning the feeding pump back on. The resident was very thin and weak. Will not increase tube feeding due to tolerance issues. Recommend decreasing flushes to 100 ml every 6 hours to help alleviate feeling of fullness. Will continue to monitor weight, skin and labs but expect further weight loss.

Review of a nursing note entry dated 3/26/18 for Resident #422 stated the tube feeding was noted to be going at 150 ml per hour instead of 80 ml per hour. Resident with stomach not distended, but complained of feeling very full. Resident given a few hours of feeding.

A physician ' s order dated 3/29/18 for Resident #422 stated to have the RD assist with transition to bolus feedings via his g-tube.

Review of a physician order dated 3/31/18 for Resident #422 stated to discontinue continuous g-tube feedings and flushes. Start a brand name tube feeding formula that provided 1.2 calories

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per ml, 480 ccs at 8:00 am, 12:00 pm and 9:00 pm, 240 ccs at 5:00 pm and 150 ml water every 6 hours via g-tube.

Review of the weights recorded in the electronic medical record (EMR) for Resident #422 revealed weight was 137.2 lbs. on 3/20/18, 135.4 lbs. on 5/6/18 and 134 lbs. on 6/6/18.

Review of a hand- written list of weights for Resident #422 provided by the RD revealed a weight of 139.6 lbs. on 3/13/18, 137.2 lbs. on 3/20/18 and 131 lbs. on 4/4/18. This reflected an 8.6 lb. / 6.1% significant weight loss in 22 days.

An interview with the RD on 6/13/18 at 11:55 am revealed the first weight she had for Resident #422 was on 3/13/18 and she had used the hospital weight for her initial nutritional assessment.

An observation on 6/13/18 at 12:30 pm of Resident #422 revealed he was in his room eating his lunch meal. He had received a Mechanical Soft diet with nectar thickened liquids. He could feed himself and consumed all of his food and fluids.

Review of a physician ' s order dated 4/3/18 for Resident #422 stated to start a brand name tube feeding formula that provided 1.5 calories per ml, 225 ml at 8:00 am and 12:00 pm, 150 ml water flush at 8:00 am, 12:00 pm, 5:00 pm and 9:00 pm, from 10:00 pm until 4:00 am run continuous feeding at 110 ml per hour with 65 ml water every hour.

Review of nursing note entries on 4/14/18 from 6:14 pm until 11:53 pm for Resident #422

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revealed a change in the resident ' s condition and he was sent out to the emergency room at 11:50 pm.

Review of the hospital record dated 4/15/18 for Resident #422 stated resident was found to be dehydrated with acute renal failure. Admission BUN (blood urea nitrogen) was 84 milligrams per deciliter (mg/dl) and improved to 34 mg/dl on 4/16/18 after administration of intravenous fluids. The normal reference range for BUN was identified as 7 to 25 mg/dl.

Review of hospital nutritional assessment dated 4/15/18 for Resident #422 stated per hospital records residents weight had decreased from 72 kilograms (kg) (158.4 lbs.) on 3/6/18 to 59.6 kg (131.1 lbs.) on 4/15/18. An approximate 17% weight loss in 5 weeks.

Review of a nursing note dated 4/16/18 for Resident #422 stated resident re-admitted to the facility at 6:25 pm.

Review of a physician ' s order dated 4/16/18 for Resident #422 stated to administer a brand name tube feeding formula that provided 1.5 calories per ml, 250 ml at 6:00 am, 12:00 pm, 6:00 pm and 12:00 am and 150 ml water flush at the same times via g-tube.

An interview on 6/14/18 at 10:54 am with the RD revealed the weight used for Resident #422 ' s nutritional assessment dated 3/2/18 was 142 lbs. She stated the Dietary Manager (DM) had obtained the weight from a nursing assistant (NA) report and it was never entered into the EMR. She added all of the resident ' s weights should be in the EMR and she didn ' t know why they

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weren ' t entered. The RD stated the facility weight protocol was to weigh all new admissions weekly for 4 weeks. She explained she had spoken to the nurses and the resident ' s family members about Resident #422 being underweight and options for his tube feedings. She added the nurses would tell her the resident was disconnecting his tube feeding. The RD stated she had assumed that the resident ' s tube feeding was being administered according to the physician ' s orders and that was how she calculated the calories, protein and fluids the resident was receiving. She added she had changed his tube feedings from continuous to bolus feedings on 3/31/18 at the request of the physician in preparation of the resident being discharged home. The RD added the resident was not discharged and she changed his tube feeding on 4/10/18 to one with a higher caloric density. She stated she hadn ' t considered changing the formula prior to that date even though she acknowledged the resident had experienced a significant weight loss. The RD added she did not believe there had been any lab work completed on the resident and she had not recommended any labs to better assess the resident ' s nutritional status.

An interview on 6/14/18 at 7:03 pm with Nurse #5 revealed she had been the nurse for Resident #422 on the evening shift (7:00 pm to 7:00 am). She stated the resident did receive tube feeding and he didn ' t have any tolerance issues on her shift. She added other nurses had reported to her that the resident would disconnect the tube feeding and let it run on the floor. Nurse #5 explained she followed the orders on the MAR and would initial the MAR that the tube feeding was given. She stated they did not record the

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exact amount of tube feeding or water flushes that were administered on their shift.

An interview on 6/16/18 at 7:15 pm with the Assistant Director of Nursing (ADON) revealed she was familiar with Resident #422. She stated the resident did not tolerate his tube feedings well and he would pull the feedings off and let them run on the floor. The ADON explained the resident had been referred to the RD because of the issues with his tube feeding. She stated the nurses were responsible to sign off on the MAR to reflect that the tube feeding was administered. The ADON added they did not typically document the exact number of ccs of formula or water that the resident received. The tube feeding care plan intervention that stated to monitor intake and output for Resident #422 was reviewed with the ADON and she stated she would interpret this as meaning the total cc ' s / volume of tube feeding and water that the resident received should have been documented. The February and March 2018 MARs were reviewed with her and she stated she was not aware that the tube feeding formula was not on the MARs for these months and she didn ' t know why his tube feeding had not been documented as being administered.

An interview on 6/15/18 at 9:52 am with Nurse #7 revealed she had cared for Resident #422. She stated the resident would refuse the tube feedings at times by pushing her hand away when she tried to administer it or he would disconnect the tube feeding and let it run on the floor. She stated they did not document the exact amount of tube feeding formula or water the resident received; she would just initial the MAR if it was given or write a "N" if refused. Nurse #7 added she would initial the MAR that the tube

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feeding was administered even if she was only able to administer a partial amount. She stated she was not aware of the care plan intervention to monitor intake and output on the Resident #422. She was also not aware that the tube feeding formula was not on the February or March 2018 MARs. Nurse #7 stated she had notified the physician and the RD of the resident ' s behaviors with his tube feeding. She added she was not aware the resident had a significant weight loss.

A phone interview on 5/15/18 at 12:19 pm with the physician for Resident #422 revealed the resident was NPO and received tube feeding for his nutritional intake. He added the resident was eating by mouth now. The physician stated he believed the facility had notified him that the resident had disconnected his feeding tube and refused his tube feeding at times. He added he could not confirm if he had been notified of his significant weight loss. The physician added the facility probably should have been monitoring the exact amount of tube feeding formula and water flushes he was receiving because of his behaviors of refusing and disconnecting the tube feeding. He stated the resident ' s actual intake would have been more accurately assessed if they were doing that. The physician explained the dehydration identified when the resident was hospitalized was likely associated with his insufficient fluid intake from his tube feeding.

An interview with the Director of Nursing (DON) on 6/15/18 at 5:01 pm revealed he expected physician ' s orders to be followed and interventions put in place to maintain the resident ' s well-being. He stated the facility should have implemented additional monitoring to ensure the resident ' s nutritional status was maintained.

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F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident interview and staff interviews, the facility failed assess a resident's pain in a timely manner and provide an intervention for pain relief for 1 of 3 residents reviewed for pain. (Resident #22). Findings included: Resident #22 was admitted to the facility on 10/12/15 with the diagnosis of muscle weakness, hypertension, and posture abnormality. A note from physical therapy dated 3/13/18 revealed that the resident was noted to have increasing left knee contraction and needed maximum assistance with transfers. The resident's annual Minimum Data Set dated 3/28/17 revealed the resident was cognitively intact. No moods or behaviors were noted. The resident required extensive assistance with bed mobility, transfers, locomotion, and dressing. The resident required limited assistance with locomotion and eating. The resident required physical help in bathing. Resident #22 had a care plan in place for pressure ulcers (dated 4/5/18) and Activities of	F 697	F697 Pain Management Root Cause Analysis Based on root cause analysis by the facility administrative staff and the executive director the nurse for resident #22 did not assess the pain the resident was having in a timely manner. Immediate Action On 6/11/18 at 8:49 am a pain assessment was done by the nurse for resident #22 and the resident declined pain medication at that time. Identification of Others All residents experiencing pain are at risk for the deficient practice, therefore, beginning 7/10/18 a review of all residents on schedule/prn pain medication will be interviewed to ensure pain is controlled. The audit will be completed by 7/11/18. The physician will be contacted for any residents with uncontrolled pain to obtain any new orders. Systemic Changes Beginning 7/13/18 the Director of Nursing/ Assistant Director of Nursing/ Unit Manager will review 5 residents to verify that pain assessment every shift is placed on the Medication administration record and that documentation is complete	7/23/18

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F 697	Continued From page 60 daily Living (initiated 3/31/17). A wound care assessment dated 5/31/18 revealed that the resident had a wound to her perineal areas that measured 3 centimeters (cm) x 2 cm x 0 cm. Review of the resident's Medication Administration Record revealed the resident had last received Acetaminophen (a medication for pain) scheduled on 6/11/18 at 6:00 AM. The resident also had orders for tramadol every 6 hours as needed for pain (ordered 5/12/18). The resident last received Tramadol on 6/13/18. A pain assessment dated 6/11/18 revealed that at 6:20 AM, the resident's pain level was a 0. Resident #22 was observed during morning care on 6/11/18 at 7:48 AM. Nursing Assistant (NA) #5 placed the shirt on resident #22. The resident was observed sitting on the edge of the bed and crying. The resident stated, "ouch and ohh" as staff assisted her with putting her shirt on. The NA stated that she would tell the nurse that the resident was having pain. The resident was still visibly crying when she was moved back in the bed from sitting in the edge of the bed. The NA #5 stated that the resident cried every time she changed her and that her leg was contracted inward. Resident #22 stated that she wanted to stay in bed when asked if she wanted to get up. NA #5 told resident #22 that she would be back to brush the resident's teeth and hair before her appointment. The surveyor asked the resident how long she had experienced pain and the resident that she had been having pain "for 2 months". The resident was interviewed on 6/11/18 at 7:57	F 697	during daily clinical meetings 5 days per week (Monday – Friday). Findings will be documented on the clinical rounds forms and filed in a clinical meeting binder By 7/13/18 licensed nursing staff will be in-serviced on assessing pain Q shift and PRN and documenting on the medication administration record. This education will be provided by the Regional Clinical Consultant from for the management consulting company. Any staff not educated will not be allowed to work until educated. This education will be added to the new hire process for all new licensed nurses. Monitoring The Director of Nursing/ Assistant Director of Nursing/Unit Manager will monitor daily during clinical meeting 5 days per week (Monday- Friday) to ensure pain assessments are being completed on any resident on a PRN/scheduled pain medication every shift on the medication administration record and that documentation is complete. This monitoring will be conducted daily (Monday through Friday) x4 weeks, then weekly x4 weeks and then monthly for 3 months. Findings will be reported monthly to the QAPI committee for recommendations or modification until a pattern of compliance is achieved. REPONSIBLE PARTY Effective 7/13/18 the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	

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AM. The resident stated that she didn't get pain medication that she knew of. She said "yes" when asked if she was having a lot of pain in her left leg. The resident stated "yes" that she could move her leg when asked. The resident was unable to answer any other questions.

Observations on 6/11/18 at 8:11 AM revealed staff delivered Resident #22's breakfast to her in her room. The resident was unable to move her left leg (which was bent) so the breakfast tray could be set up on the bedside table over the resident. She stated that she "would try" when asked to move her leg by NA#2. However, the resident was unable to move her leg. NA #5 said that the resident's leg was hurting and they were going to give her something for it. The resident was sat up with the assistance of 2 NAs on the edge of bed. The resident stated, "hurt and oh" as the staff sat her up on the bed. The resident was then stood and pivoted on 1 leg with the assistance of NA #5 and #6 to the wheelchair. The resident's hair was combed and teeth were brushed in the bathroom with help from NA #5. The resident was then sat up for breakfast. The resident was able to feed herself in her wheelchair.

A continuous observation from 7:48 AM to 8:49 AM on 6/11/18, revealed the resident was not assessed for pain.

Nurse #3 was observed to enter the patient's room on 6/11/18 at 8:28 AM. She asked the resident if she was ready for her appointment today and the resident answered "yes".

Nurse #3 was observed again on 6/11/18 at 8:30 AM giving the resident her morning medications.

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Resident's #22 pain was not assessed or asked about. The resident was not given any medications for pain. Nurse #3 told the resident that she would right back and that she had to get her Miralax (a medication for constipation.)

Nurse #3 came when back to the resident's room on 5/11/18 at 8:49 AM with the Miralax medication. Nurse #3 asked the resident if she was having pain and the resident stated that her "butt hurts".

Nurse #3 stated that she could give the resident some pain medication for it. The resident stated that "it just hurts, I'll put it like that." The resident also stated that right now her pain was on her butt and she could feel it. The resident then stated "no" when asked if she wanted medication for the pain right now.

A nursing note dated 6/11/18 at 9:07 AM stated that the resident told the aid that she as having pain and the nurse went in to give the resident medication. The resident stated that her back was sore and she does not want pain medication at this time.

Nurse #3 was interviewed on 6/11/18 at 2:35 PM. She stated that the resident had pain sometimes and had scheduled pain medication. She stated that the resident would tell her when she is having pain and sometimes would take pain medications and other times, she will not. She stated that she would assess the resident's pain every shift and as needed. She stated that after we went in (the first time), she went back in and assessed the resident's pain again and the resident stated that she didn't have any pain an hour later. The Nurse stated that resident #22 had pain to her butt and

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groin and also had pain from a wound on her leg. She stated that NA #5 told her that the resident was having pain this morning when she was standing outside of room 405. She stated that as soon as she finished giving the resident medication in that room, she went to resident's #22 room. She stated that she could not remember the exact amount of time it took her but she thought it was less than 15 minutes or so. She stated that if the resident was crying then she would find out why and would try to talk to the resident and the resident's family. She would also let the doctor know if possible and referred the resident to someone if needed. She stated that it had never been reported to her that the resident had intermittent crying that she knew of.

NA #5 was interviewed 6/11/18 at 2:55 PM. She stated that resident #22 could use the call bell and tell you what she wanted and doesn't want. She stated the resident couldn't use her leg so she was changed every 2 hours and she was incontinent. She stated the resident had a boil on her buttock and it would hurt her sometimes. She added that the resident's leg and that the resident's leg was always contracted. She stated that sometimes the resident would cry when she was providing care and sometimes it (the pain) wasn't as bad. The resident's crying was about the same as usual today. She stated that she told nurse #3 that the resident was having pain and needed pain medication. She stated that she didn't know the exact time but guessed it was around 8:00 AM. The resident would sometimes want to just lay in the bed depending on her pain and so she just let the resident lay down until she wanted to get up. She stated that they couldn't get the tray across the resident this morning so they had to get her up to eat. She stated that

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F 697	Continued From page 64 normally she can get the resident up on her own but the way the resident was hurting this morning, she got help from another NA. She stated that the resident could pivot on 1 leg for transfers. NA #5 was interviewed again on 6/13/18 at 9:40 AM. NA #5 was asked if she knew why it took an hour for the resident to get her pain assessed. She responded by stating that nurse #5 was near room 405 and was passing medications when she told the nurse that the resident was having pain yesterday. The Director of Nursing was interviewed on 6/13/18 at 2:40 PM. He stated whoever finds the patient having pain should report to the nurse and the nurse should assess the resident as soon as possible to address the issue.	F 697		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with	F 725		7/23/18

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F 725	Continued From page 65 resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review, observations, staff interview and resident interview the facility failed to provide sufficient nursing staff to provide incontinence care and answering call bells for 1 of 4 residents (Resident #117). The facility failed to provide timely pain management for 1 of 3 residents (resident #22). Findings included: This tag was crossed referenced to: F550: Based on record review, resident and staff interviews the facility failed to provide care in a manner to maintain the resident's dignity by not providing timely incontinence care for a resident that had a bowel movement (Resident #117). This was evident in 1 of 4 residents reviewed for dignity. F697: Based on record review, observations, resident and staff interviews, the facility failed to assess a resident's pain in a timely manner and provide interventions for pain relief for 1 of 3 residents reviewed for pain (Resident #22). During an interview with Nursing Assistant (NA)	F 725	F725 Sufficient Staffing Root Cause Analysis Based on root cause analysis by the facility administrative staff and the executive director the nurse and CNA failed to respond to resident # 117 in assisting in toileting and resident #22 assessing pain in a timely manner. Immediate Action On 6/11/18 at 8:49 am a pain assessment was done by the nurse for resident #22 and the resident declined pain medication at that time. On 6/10/18 learning of the need of the resident by the Executive Director, the Executive Director had the resident changed by CNA # 5 and the nurse. CNA was counseled and reeducation by the Executive Director. Systemic Changes By 7/13/18 licensed nursing staff will be in-serviced on assessing pain Q shift and PRN and documenting on the medication administration record. This education will be provided by the Regional Clinical Consultant from for the management consulting company. Also, by 7/13/18 all	

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F 725	Continued From page 66 #5) on 6-14-18 at 3:44pm she stated she was the only NA for hall 500 on 6-10-18 and that her supervisor had removed the other aide that was working with her to another hall. The NA also stated she had 14 residents to care for and there was a delay in answering the call bells. A review of the schedules for 6-14-18 revealed one nursing assistant on hall 500 for the 7:00am to 3:00 pm shift. An interview with the Administrator occurred on 6-14-18 at 4:00 pm who stated she was aware that the NA was on hall 500 by herself and that she had to move the other NA off hall 500 to administer medication. The Administrator stated she did not attempt to call anyone else in to work to help the NA on hall 500 and felt there was enough staff to help. The Administrator was interviewed on 6-14-18 at 6:15pm. The Administrator stated she expected that there would be sufficient staff to meet the resident's needs.	F 725	CNA's will be inservice on reporting pain immediately to the hall nurse for any resident stating or showing signs of being in pain. This education will be added to the new hire process for all new licensed nurses. The facility will ensure that, after review of the nursing administration recommendations on level of assistance, the needed staff is scheduled per hall to accommodate resident's needs. A copy of the staffing needs per hall will be given to the unit managers and placed in the unit schedule book at each station. The Medical Records Director will be in charge of completing daily staffing sheets with the needed staff outlined. Effective 7/13/2018 nursing staff will be in-serviced on providing timely assistance with toileting. The education will be provided by the Director of Nursing/ Assistant Director of Nursing. This education will be added to the new hire process for new nursing staff. A copy of the inservice will be kept in a binder in the Executive Directors office. Monitoring The Director of Nursing/ Assistant Director of Nursing/Unit Manager will monitor daily during clinical meeting 5 days per week (Monday- Friday) to ensure pain assessments are being completed on any resident on a PRN/scheduled pain medication every shift on the medication administration record and that documentation is complete. This monitoring will be conducted daily x4 weeks, then weekly x4 weeks and then monthly thereafter. Effective 7/16/2018	

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F 725	Continued From page 67	F 725	the Director of Nursing / Assistant Director of Nursing will interview 5 residents to ensure the resident is getting the needed assistance with toileting daily 5 days per week (Monday – Friday) for six weeks then 3 days a week for four weeks . . Findings will be reported monthly to the QAPI committee for recommendations or modification until a pattern of compliance is achieved. REPONSIBLE PARTY Effective 7/13/18 the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	
F 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 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	F 761		7/23/18

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F 761	Continued From page 68 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 store medications at the refrigeration temperature specified by the manufacturer in 1 of 2 Medication Rooms (100/200 Hall Med Room); and, failed to label an insulin pen stored on 1 of 3 medication carts (200 Hall med cart) with the name of the specific resident for whom it was prescribed and the date it was opened. The findings included: 1) Accompanied by Nurse #1, an observation was made of the 100/200 Hall Medication Room (Med Room) on 6/15/18 at 11:45 AM. A thermometer hanging from the middle shelf of the Med Room refrigerator indicated the temperature was 26 degrees Fahrenheit (o F). The contents of the refrigerator at the time of the observation included: --4 unopened Levemir insulin pens; --2 unopened vials of Lantus insulin; --1 unopened vial of Humulin N insulin; --1 unopened vial of Levemir insulin; --1 unopened vial of Novolin R insulin; --1 unopened vial of Novolin N insulin; --2 unopened vials of 10,000 units/milliliter (ml) Procrit (an injectable medication used to stimulate red blood cell production); --1 opened vial of Tuberculin PPD (used for skin	F 761	F761 Label/Store Drugs and Biologicals Root Cause Analysis Based on root cause analysis by the facility administrative staff and the executive director the nurse #1 failed to ensure the temperature range for the medication refrigerator was within the manufactures ranged for the stored medication. Nurse #2 failed to ensure that an open Novolog Insulin pen had the correct resident name and the date it was opened Immediate Action: As of 7/10/18 the facility removed all medications that were in that refrigerator and it as discarded and re-ordered by DON. Medication refrigerators in the facility were audited to ensure temperature ranges were within manufactures recommendations. As of 7/10/18 medications carts have been audited to ensure no unlabeled open Insulin pens are out of compliance. These audits are maintained in a binder in the ED office. Identification of others: An audit will be completed by the administrative nurses to identify any other unlabeled open medication to ensure compliance. An audit of all medication	

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F 761	Continued From page 69 test in the diagnosis of tuberculosis); --2 unopened Avonex pens (an injectable medication used for the treatment of multiple sclerosis); --1 partial box of Brovana nebulization solution (an inhalation medication used in the treatment chronic obstructive pulmonary disease); --1 plastic bag with 18 unopened foil pouches containing Brovana nebulization solution; --1 30-count box of Perforomist vials of nebulization solution (an inhalation medication used in the treatment of asthma or chronic obstructive pulmonary disease); --1 unopened bottle of 200 units/spray calcitonin-salmon nasal spray (used in the treatment of postmenopausal osteoporosis). An interview was conducted on 6/15/18 at 11:45 PM with Nurse #1. During the interview, the nurse was asked what the appropriate temperature range for the medication refrigerator should be. The nurse stated, she was "not sure." Upon request, Nurse #1 retrieved the June 2018 refrigerator temperature log from a binder kept at the nursing station. A blank at the top of the temperature log read, "Acceptable Range:" This blank was not filled out; the log did not indicate what the acceptable temperature range was supposed to be for the medication refrigerator. Upon further review, the June 2018 temperature log included the following temperatures, in part: On 6/7/18, the refrigerator temperature was 32o F; On 6/11/18, the refrigerator temperature was 28o F; On 6/12/18, the refrigerator temperature was 32o F; On 6/13/18, the refrigerator temperature was 32o F;	F 761	refrigerators have been inspected by administrative nurses on 7/10/18 to identify any medications are within manufactures recommend temperature range. Any expired items identified will be discarded and re-ordered. Systemic Changes: By 7/13/18 licensed nursing staff will be in-serviced on ensuring temperature sheet log has accepted temperature range labeled at top and that all temperatures are within the acceptable range. If the temperature is outside of acceptable range the nurse will immediately notify the maintenance director for inspection. By 7/13/18 licensed nursing staff will be in-serviced on ensuring all opened medication has the resident s name and date that the medication is clearly marked. This education will be added to the new hire process for all new licensed nurses. Monitoring The Director of Nursing/ Assistant Director of Nursing/Unit Manager will monitor daily during clinical meeting 5 days per week (Monday- Friday) to ensure all medication refrigerator temperature log are filled in and that the temperature is within the acceptable manufacturers range. This monitoring will be conducted daily x4 weeks, then weekly x4 weeks. The Director of Nursing/ Assistant Director of Nursing/Unit Manager will monitor daily during clinical meeting 5 days per week (Monday- Friday) to ensure all opened medication in the medication carts are clearly labeled with the resident name and date opened. This monitoring will be conducted daily x4 weeks, then	

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F 761	Continued From page 70 On 6/14/18, the refrigerator temperature was 32o F. A review of the manufacturers ' product information for the individual medications stored in the 100/200 Hall Medication Room refrigerator included the following storage requirements: -- Unopened Levemir insulin pens may be stored in a refrigerator (36o - 46o F); Do not freeze. -- Unopened vials of Lantus insulin may be stored in a refrigerator (36o - 46o F); Do not freeze. -- Unopened vials of Humulin N insulin may be stored in a refrigerator (36o - 46o F); Do not freeze. -- Unopened vials of Levemir insulin may be stored in a refrigerator (36o - 46o F); Do not freeze. -- Unopened vials of Novolin R insulin may be stored in a refrigerator (36o - 46o F); Do not freeze. -- Unopened vials of Novolin N insulin may be stored in a refrigerator (36o - 46o F); Do not freeze. -- Unopened vials of Procrit should be stored in a refrigerator (36o - 46o F); Do not freeze. -- Unopened and opened vials of Tuberculin PPD should be stored in a refrigerator (35o - 46o F); Do not freeze. -- Unopened Avonex pens should be stored in a refrigerator (36o - 46o F); Do not freeze. -- Brovana solution for nebulization may be stored in a refrigerator (36o - 46o F); -- Perforomist vials may be stored in a refrigerator (36o - 46o F); -- Unopened bottles of calcitonin-salmon nasal spray should be stored in a refrigerator (36o - 46o F); Protect from freezing. An interview was conducted on 6/15/18 at 12:16	F 761	weekly x4 weeks. Findings will be reported monthly for 3 months to the QAPI committee for recommendations or modification until a pattern of compliance is achieved. REPONSIBLE PARTY Effective 7/13/18 the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	

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F 761	Continued From page 71	F 761		

PM with the facility ' s Director of Nursing (DON). During the interview, the June 2018 temperature log was reviewed and the temperature reading of the medication room refrigerator taken on 6/15/18 at 11:45 AM was discussed. The DON reported the acceptable temperature range for the medication room refrigerator was 36o - 46o F. Upon review of the temperature log, the DON stated, "(The temperature) looks like its treading down." When asked what his expectation was in regards to monitoring the medication room refrigerator, the DON stated the 3rd shift nurse was supposed to check and record the temperature of the med room refrigerator. He reported if the temperature of the refrigerator was too low, the nurse was supposed to notify "us." When the DON was asked to specify who was supposed to be notified, he stated that he (the DON) was supposed to be notified. The DON was then asked if he had been notified of the med room refrigerator temperatures being outside of the acceptable range. The DON stated, "No."

2) An observation was made of the 200 Hall Medication Cart (Med Cart) on 6/15/18 at 11:22 AM. The observation revealed an opened Novolog insulin pen was stored on the 200 Hall Med Cart. The insulin pen appeared to have two letters written on it with a black marker; however, the first letter was not legible. The insulin pen was not labeled with the name of the specific resident for whom it was prescribed nor was it labeled with the date the pen was opened.

An interview was conducted on 6/15/18 at 12:05 PM with the 200 Hall nurse (Nurse #2) and the facility ' s Staff Development Coordinator (SDC). Nurse #2 and the SDC were shown the unlabeled

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F 761	Continued From page 72 Novolog insulin pen stored on the med cart. Neither Nurse #2 nor the SDC could identify who the insulin pen belonged to. Upon inquiry, the SDC stated the insulin pen needed to be labeled with the resident's name and date. When asked if labeling the insulin pen with a resident ' s initials would be sufficient, the SDC stated, "No." An interview was conducted on 6/15/18 at 12:16 PM with the facility ' s Director of Nursing (DON). During the interview, the DON was asked how he would expect an insulin pen to be labeled. The DON stated he would expect an insulin pen to be labeled with the resident ' s name and the date it was opened.	F 761		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident and staff interviews the facility failed to honor the food preferences for 1 of 2 sampled residents reviewed for choices and preferences. (Resident #421). Findings Included:	F 806	F 806 Resident Allergies, Preference, Substitutes Root Cause Analysis Based on root cause analysis by the facility administrative staff and the dietary manager the dietary aide failed to honor the preference for resident #421 in giving the resident pork when it was labeled on	7/23/18

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F 806	Continued From page 73 Resident #421 was admitted to the facility on 11/10/16 and cumulative diagnoses included late onset of Alzheimer's disease. An annual minimum data set (MDS) assessment dated 4/6/18 for Resident #421 identified she received a therapeutic diet, required limited assistance with eating and with moderately impaired cognition. A review of the June 2018 physician orders for Resident #421 identified an order for a regular no added salt diet. An observation of Resident #421 on 06/10/18 at 12:29 PM revealed she was served her lunch meal. Observations of the food served on the resident's meal tray revealed she had been served roast pork and which was not eaten by the resident. An interview with Resident #421 on 06/10/18 at 12:31 pm revealed she does not like or eat pork. Review of the tray card that was present on Resident #421's lunch meal tray on 6/10/18 revealed she was on a regular no added salt diet and pork was identified as an allergy on the tray card. An interview on 6/15/18 at 4:15 pm with the Dietary Manager (DM) revealed Resident #421should not have been served the pork. The DM stated the pork preference was missed because there was a new dietary aide (first day at work) on the food line. Continued interview revealed the cook does not look at the tray cards when plating foods and expected the staff who served the resident's tray look at the tray card.	F 806	the tray card as a dislike. Immediate Action: The dietary manager along with the ED inserviced the dietary aide on carefully reading and honoring any food preferences on the tray card. Identification of others: Residents with specific food preferences have the potential to be affected by this practice therefore the dietary manager will interview all residents by 7/13/18 to ensure all food preferences are clearly marked on the residents tray card. Systemic Changes: By 7/13/18 all dietary staff will be inserviced by the dietary manager on the importance of honoring food preferences and on reading the tray card to ensure all preferences are being honored by the facility. This education will be added to the new hire process for all new dietary staff. Monitoring The Dietary Manager will audit at least 10 trays/ 2 meals a day Monday through Friday alternating meals for two weeks then 10 trays one meal a day alternating meals for two additional weeks. Findings will be reported monthly for 3 months to the QAPI committee for recommendations or modification until a pattern of compliance is achieved. REPONSIBLE PARTY Effective 7/13/18 the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	

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F 806	Continued From page 74 The DM stated Resident #421 should not have been served the pork because of her preference and she was not allergic to pork. An interview on 6/15/18 at 4:22 PM with Director of Human Resources (DHR) revealed she had served Resident #421 her lunch meal on 6/15/18. DHR stated she does not look at the tray cards on resident meal trays prior to serving a resident their meal to see if the resident's meal tray contains any food dislikes or allergies. On 06/15/18 at 4:39 PM another tray card was provided by the DM that indicated Resident #421 disliked pork.	F 806		
F 812 SS=E	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. §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	F 812		7/23/18

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F 812	Continued From page 75 by: Based on observations and staff interviews, the facility failed to discard expired food and beverages stored in 1 of 1 kitchen reach- in refrigerators and in the kitchen's dry storage area. Findings included: Items stored in the kitchen's reach- in refrigerator were observed on 6/10/18 at 2:20 PM and revealed the following: - A large plastic container of opened pickles that had a hand-written notation of "opened 12/25" written on its top and had another written date of 3/30 on top of the container. There was no expiration date on the container. - A large container of prepared yellow mustard had an expired best by date of 11/24/17. The container also had a hand -written date of 9/18 on the top of it. - A large container of opened Sweet relish had a hand-written date of 4/27 on the top of the container. There was no expiration date on the container. - There was one container of thickened sweet tea that did not have the date it was opened on it date and was ½ full with an expiration date of 9/12/18. - A pitcher of a brown liquid (appearance was similar to tea) was covered but there was no label or date when it was made. Interview with the Assistant Dietary Manager (ADM) on 6/10/18 at 2:20 PM revealed that she thought the pickles were opened on 12/25/17 and	F 812	F 812 Food Safety Requirements Root Cause Analysis Based on root cause analysis by the facility administrative staff and the dietary manager the dietary staff failed to remove expired foods from the refrigerator and the dry storage area and also failed to clearly label items in the refrigerator. Immediate Action: The ED on 6/13/18 immediately upon learning of the expired food discarded the food. All unlabeled food or liquid was also discarded. The dietary manager will update the cleaning schedule to ensure the inspections of the refrigerator (removing expired foods, labeling of foods) and the dry storage room are in compliance. Identification of others: All residents have a potential to be affected by this practice therefore an audit of the entire kitchen was completed and any other expired food or any food that was unlabeled was discarded. Systemic Changes: By 7/13/18 the dietary manager will inservice dietary staff on proper procedure for safe storage of food items in storage areas, walk in, and freezer. Also the dietary staff will be inserviced on the cleaning schedule to ensure all tasks are completed timely. Monitoring Effective 7/13/18 The Dietary Manager will audit daily Monday through Friday the cleaning schedule and inspection of the	

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F 812	Continued From page 76 3/30/17 was the date that they initially came in (to the facility). She stated the aids on the cleaning assignments were supposed to check the items to ensure they were in date. She stated she tells everyone to always check the dates and label everything. (The ADM also looked and could not find the label for the brown liquid). The ADM threw out the mustard, relish and pickles. The dry storage area was observed on 6/13/18 at 7:32 AM. - An unopened large container of Picante Sauce had an expiration date of 4/3/18. - Two unopened large containers of the Picante Sauce had an expiration date of 4/25/18. The Dietary Manager was interviewed on 6/13/18 at 8:58 AM. She stated that usually the containers of pickles were good for 1 month after they are opened and they usually didn't have an expiration on the actual jug so they would put the opened date on them. She stated that the Picante sauce was unopened so she didn't think that it was expired. She also added that they didn't use much Picante sauce at the facility. The Administrator was interviewed was 6/13/18 at 2:26 PM. She stated she would expect for the staff to be labeling products and removed expired products from the storage area. She stated that she was unaware of any kitchen concerns of expired foods.	F 812	refrigerators and dry storage areas for any expired or unlabeled foods. These audit will continue on Saturday and Sunday by the lead cook daily for four weeks then 3 days a week for four additional weeks. Findings will be reported monthly for 3 months to the QAPI committee for recommendations or modification until a pattern of compliance is achieved. REPONSIBLE PARTY Effective 7/13/18 the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is	F 842		7/23/18

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F 842	Continued From page 77	F 842		

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

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

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

§483.70(i)(3) The facility must safeguard medical

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F 842	Continued From page 78 record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to maintain documentation of insulin administration for 1 of 8 residents reviewed for unnecessary medications (Resident #117). Findings Included: Resident #117 was admitted to the facility on 5/23/18 and her diagnoses included diabetes, atrial fibrillation, congestive heart failure, chronic kidney disease and depressive disorder. An admission minimum data set dated 5/30/18 for Resident #117 revealed she had received insulin	F 842	F 842 Resident Records □ Identifiable Information Root Cause Analysis Based on the root cause analysis by the facility administrative staff and the Executive Director it was determined the facility failed to follow policy and procedure for entering an insulin order correctly to allow for the nurses to properly document units given. Immediate On 6/20/18 an order was obtained from the physician to clarify insulin sliding scale. The order has been correctly	

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F 842	Continued From page 79 7 days of the look-back period and her cognition was intact. A care plan dated 5/30/18 for Resident #117 identified she had a potential for alteration in blood sugars related to diabetes. Interventions included to administer medications as ordered, monitor blood sugar as ordered and document on the medication administration record (MAR). Review of a physician ' s order for Resident #117 dated 6/6/18 stated to start Novolog insulin 100 units / milliliter (ml), inject number of units subcutaneously according to the following scale (blood glucose minus 150 divided by 25 equals the number of units to give). Review of the June 2018 MAR for Resident #117 revealed an order with a start date of 6/6/18 for Novolog insulin 100 units / milliliter (ml), inject number of units subcutaneously according to the following scale (blood glucose minus 150 divided by 25 equals the number of units to give). There was a check mark and a blood sugar result documented from 6/6/18 through 6/13/18 at 6:00 am, 11:30 am, 4:30 pm and 9:00 pm. The number of units of insulin administered was not documented on the MAR. An interview on 6/14/18 at 2:37 pm with Nurse #9 revealed she has been the nurse for Resident #117. She stated the resident had a consult with an Endocrinologist and he changed her sliding scale insulin order to the order written on 6/6/18. She stated she would check the residents blood sugar and then use a calculator to calculate how many units of insulin the resident should receive. Nurse #9 stated the MAR should have included a place to document the number of units of insulin	F 842	entered into the electronic record to include special instructions for this special sliding scale. Identification of Others Residents requiring sliding scale insulin orders are at risk for the deficient practice therefore an audit was completed by nursing administration on 7/8/18 to ensure all sliding scale insulin orders have been entered into the electronic record to ensure documentation of insulin given. Systemic Changes By7/13/18 licensed nurses will be inserviced by the Director of Nursing and Asst. Director of Nursing on administering medications as ordered and the documenting. Licensed nursing staff has also been in-serviced on entering sliding scales insulin orders to ensure documentation of insulin given. Monitoring Effective 7/13/18 The Director of Nursing/ Assistant Director of Nursing/Unit Manager will monitor daily during clinical meeting 5 days per week (Monday-Friday). Observation will consist of ensuring medications are being documented as ordered. New orders will be reviewed in morning clinical meeting and the unit managers will ensure that orders have been entered correctly in the electronic record. This monitoring will be conducted 5x per week for 4 weeks, then weekly x4 weeks. Findings will be reported to the QAPI committee for3 months for recommendations and modifications until a pattern of compliance is achieved. REPONSIBLE PARTY Effective 7/13/18	

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	345529	A. BUILDING _____ B. WING _____	C 06/15/2018

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F 842	Continued From page 80 given and this needed to be corrected. An interview on 6/15/18 at 9:58 am with Nurse #7 revealed Resident #117 had gone to see an Endocrinologist and he ordered a new sliding scale insulin. She stated this was different than the way they typically administered sliding scale insulin because they had to do a calculation each time to determine how many units of insulin to give. Nurse #7 added she didn ' t know why the actual units of insulin administered were not documented on the MAR, but they should have been. She stated who ever entered the order in the computer must not have entered it correctly. An interview with the Director of Nursing (DON) on 6/15/18 at 5:09 pm revealed each time Resident #117 received sliding scale insulin the number of units should have been documented on the MAR.	F 842	the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	
F 865 SS=E	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.	F 865		7/23/18

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F 865	Continued From page 81 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 observations, record reviews, and resident and staff interview the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place following the Annual Recertification and complaint survey of 10/26/17. This was for 2 recited deficiencies which was originally cited during the annual recertification and complaint 10/26/2017, were subsequently cited again during the complaint survey of 4/15/18. The repeat deficiencies were in the areas of F550 Dignity and F585 Grievances. During the Annual recertification and complaint survey of 6/15/18, four tags were recited that were originally cited during the Annual recertification and complaint survey of 10/26/17. The four repeat deficiencies were in the areas of F550 dignity, F585 grievances, F641 accuracy coding and F761 medication storage. The continued failure of the facility during three federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance program. Findings included: This tag is cross referred to: 1. F550 (previously tag F241) Based on record review, resident and staff interviews the facility failed to provide care in a manner to maintain the resident's dignity by not providing timely incontinence care for a resident that had a bowel movement (Resident #117). This was evident in 1	F 865	F 865 QAPI Program, Disclosure / Good Faith Attempt Root Cause: Based on resident interviews and staff observation the facility QAPI Program has been ineffective in maintaining compliance with state guidelines. Immediate Action Immediate action as stated above in each cited tag. I Identification of Others Residents residing at the facility have the potential to be affected by this alleged deficient practice. Systemic Changes The facility will institute the following measuring to ensure the allege deficient practice not occur. On 7/10/18 Regional Clinical Consultant from for the management consulting company will inservice the administrative team on the QAPI process. The facility will diligently follow policy and procedure of the QAPI process to maintain compliance. The Administrator , Director of Nursing and Unit Managers will meet weekly to review daily audits in all areas of the Plan of Correction. The Administrator and Director of Nursing will compile finding of daily and weekly audits and identify trends. The findings will be reviewed for modification. The weekly audits will be reported during the monthly Quality Assurance Performance Improvement	

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F 865	Continued From page 82 of 4 residents reviewed for dignity. During the recertification survey dated 10/26/2017, the facility was cited for F 241 for failing to provide care in a manner to maintain the resident's dignity by not answering call bells timely for resident needing assistance with activities of daily living (Resident #133 and Resident # 198) and by allowing a resident to set in a wet diaper for 5.5 hours. (Resident #126). This was evident by 3 of 3 residents reviewed for dignity. 2. F 641 (previously tag F-278) Based on record review and staff interview the facility failed to accuracy code on the Minimum Data Set (MDS) assessment for 1 of 2 residents reviewed for behaviors (Resident #120), 1 of 7 residents reviewed for unnecessary medications. (Resident # 117), and 1 of 5 residents reviewed for pain management (Resident #105). During the recertification and complaint survey dated 10/16/2017, the facility failed to accurately code the Minimum Data Set (MDS) for wandering behavior (Resident #198) and for level of assistance needed with eating (Resident #88) for 2 of 4 residents reviewed for Activities of Daily Living (ADL's). 3, F585 (previously F 165) Based on record review and interviews, the facility failed to address and document the corrective action taking for grievance issues in the areas of snacks, dirty nails, and an ongoing cough, flakey skin and treatment, weight loss, and how to contact the physician for 1 of 5 residents reviewed for grievances (Resident #318).	F 865	Committee meetings. This process will continue weekly for 4 weeks, monthly for 4 months. Results of the monitoring process mentioned above will be reported to the facility Quality Assurance, Performance Improvement committee by Director of Nursing, Assistant Director of Nursing and/or Unit manager monthly x 6 months. The QAPI committee will recommend any additional monitoring needs or modification of these plans as the committee deems appropriate.	

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F 865	Continued From page 83 During the recertification and complaint survey dated 10/26/2017, the facility the facility failed to investigate and resolve grievances for 1 of 1 resident that was reviewed for grievances (Resident #198). 4. F 761 (previously tag F431) Based on observations and staff interviews, the facility failed to store medications at the refrigeration temperature specified by the manufacturer in 1 of 2 Medication Rooms (100/200 Hall Med Room); and, failed to label an insulin pen stored on 1 of 3 medication carts (200 Hall med cart) with the name of the specific resident for whom it was prescribed and the date it was opened. During the recertification and complaint survey dated 10/26/2017 the facility failed to store medications in an upright position per the manufactures instructions for 1of 2 medication carts observed. During with the Administrator on 6/15/18 at 7:15pm she stated expectation that we meet the regulation as it related to QAPI, and that we identified issues and monitor the issues and are in compliance with the regulation.	F 865		