

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/31/2018  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                        |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>345254</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>06/14/2018</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>MONROE REHABILITATION CENTER</b> |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1212 SUNSET DRIVE EAST</b><br><b>MONROE, NC 28112</b>               |                      |   |
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| F 000   | INITIAL COMMENTS<br><br>There were no deficiencies cited as a result of this complaint investigation survey of 6/14/18. Event ID#2RB011.  | F 000   |   |                      |   |
| F 636<br>SS=E   | Comprehensive Assessments & Timing<br>CFR(s): 483.20(b)(1)(2)(i)(iii)<br><br>§483.20 Resident Assessment<br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.<br><br>§483.20(b) Comprehensive Assessments<br>§483.20(b)(1) Resident Assessment Instrument.<br>A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:<br>(i) Identification and demographic information<br>(ii) Customary routine.<br>(iii) Cognitive patterns.<br>(iv) Communication.<br>(v) Vision.<br>(vi) Mood and behavior patterns.<br>(vii) Psychological well-being.<br>(viii) Physical functioning and structural problems.<br>(ix) Continence.<br>(x) Disease diagnosis and health conditions.<br>(xi) Dental and nutritional status.<br>(xii) Skin Conditions.<br>(xiii) Activity pursuit.<br>(xiv) Medications.<br>(xv) Special treatments and procedures.<br>(xvi) Discharge planning.<br>(xvii) Documentation of summary information | F 636   |   | 7/12/18              |   |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

07/05/2018

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

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| F 636   | <p>Continued From page 1</p> <p>regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).</p> <p>(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.</p> <p>§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.</p> <p>(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)</p> <p>(iii) Not less than once every 12 months. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interviews, the facility failed to complete care area assessments (CAA) accurately and comprehensively that addressed and provided an analysis of underlying causes and contributing factors for triggered areas of activities and psychosocial wellbeing for 4 of 23 residents reviewed (Resident #73, #71, #82 and #99 ) resulting in the functional status not being addressed in the individualized care plans.</p> | F 636   | <p>1. The process that leads to the deficiency cited: The Activities Director and Social Service Director were inappropriately dashing section C,D, &amp; F of the MDS( Minimum Data Set) and as a result not completing CAA's ( Care Area Assessments) with sufficient information. The Activities Director and Social Service Director were not completing the interviews and CAA's (Care Area Assessments) per the RAI (Resident</p> |                      |   |

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| F 636   | <p>Continued From page 2</p> <p>Findings included:</p> <p>1. Resident # 73 was admitted to the facility on 11/10/2017 with diagnoses that included cerebral infarction, anxiety, vascular dementia and single episode of major depressive disorder.</p> <p>A significant change in status Minimum Data Set (MDS) dated 2/9/2018 was not completed for Sections C (Cognitive Patterns) and F (Preferences for Customary Routine and Activities) for Resident # 73. The MDS revealed Resident # 73 required extensive assistance with bed mobility and dressing and she was totally dependent on staff for transfers, personal hygiene, eating, bathing and toilet use. No mobility devices were used.</p> <p>Review of the CAA worksheet, signed and dated by the Activities Director (AD) as completed on 2/19/2018 indicated activities triggered. There was no analysis of findings or individualized summaries explaining the nature of the conditions, activity preferences, activity pursuits, environmental or staffing issues that hindered participation, skills and knowledge the resident possessed or identified issues that resulted in reduced activity participation for Resident # 73.</p> <p>An interview with the AD on 6/14/2018 at 2:26 PM revealed she did not know she could interview the staff to complete the CAA. She revealed she usually interviewed staff about residents with cognition deficits. The AD stated that she did not interview staff or family about Resident # 73.</p> <p>Review of the CAA worksheet signed and dated by the Social Worker (SW) as completed on 2/23/2018 indicated psychosocial well-being</p> | F 636   | <p>Assessment Instrument) manual because they were not aware of the correct way to complete them.</p> <p>2. What was done to correct deficient practice: On July 2, the Lead Minimum Data Set (MDS) Registered Nurse (RN) was educated by the Clinical Process Analyst on section 20500 of Resident Assessment Instrument (RAI) regarding verifying assessment completion and coding instructions. On June 20th and July 2, 2018, the Lead Minimum Data Set (MDS) Registered Nurse (RN) provided education to the Social Service Director and Activities Director on appropriate completion of the Brief Interview for Mental Status (BIMS), Mood, and Activity Preference interviews and the Care Area Assessments (CAA's) completion of the MDS. Significant Corrections to the Prior Comprehensive assessment MDS's were created for residents' #73, #71, #82, #99 and will be completed by July 12, 2018. Additionally an audit of the previous 30 days of current resident assessments was completed on July 2, 2018 and no additional assessments were noted to have the same deficient practice.</p> <p>2. All residents are at risk for the same deficient practice. As of July 2, 2018 and moving forward Brief Interviews for Mental Status (BIMS), mood interviews, activity preference interviews and Care Assessment Areas completed by the Activity Director and Social Service Director will be reviewed by the lead Minimum Data Set (MDS) Registered</p> |                      |   |

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| F 636   | <p>Continued From page 3</p> <p>triggered. There were no individualized summaries that explained how environmental factors, personal strengths, factors of relationships and lifestyle affected Resident # 73 psychosocial wellbeing and day to day functionality.</p> <p>An interview with the SW on 6/14/2018 at 3:05 PM revealed that she was aware that the CAA was for review of the problem, a summary of problems and how the facility fixed the problems. The SW revealed that she did not complete the CAA because she wrote in her progress notes. The SW indicated that she will be more detailed in her analysis and summaries in the future.</p> <p>An interview with MDS Nurse # 1 and Nurse # 2 on 6/14/2018 at 4:29 PM revealed they were aware of errors in coding, missing/dashes in MDS and incomplete CAAs. MDS Nurse # 1 stated that she will make certain that all MDS, CAAs and care plans are completed in full, prior to sending and transmitting.</p> <p>An interview with the Director of Nursing (DON) on 6/14/2018 at 4:40 PM revealed that she expected MDS, CAAs and care plans to be completed by each member of the interdisciplinary team before being signed and transmitted. The DON further revealed that she expected each ICP team member to follow the guidelines in the RAI manual, as written without exception and compare the previous OBRA MDS. She also expected each ICP team member to ask the MDS Nurses for direction or contact the Raleigh office.</p> <p>2. Resident #71 was admitted to the facility on 06/03/2010 with diagnoses which included</p> | F 636   | <p>Nurse(RN)for completion prior to submission to CMS (Centers for Medicare &amp; Medicaid Services )</p> <p>3. To ensure the plan of correction is effective, a random audit of 10 comprehensive assessments Care Area Assessments (CAA's) will be reviewed by the DON ( Director of Nursing ) monthly x 3 months. This number was determined by the number of comprehensive assessments submitted monthly to the Centers for Medicare and Medicaid (CMS).</p> <p>4. The results of the audits will be submitted to the Quality Assessment and Assurance (QAA) Committee to evaluate the need for ongoing audits after 3 months with the intent of achieving 100% accuracy.</p> |                      |   |

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| F 636   | <p>Continued From page 4 anxiety and depression.</p> <p>The significant change in status Minimum Data Set (MDS), dated 11/16/2017, indicated the resident was severely cognitively impaired and had some physical behaviors directed toward others. It also indicated the resident required extensive assistance from staff for mobility on the unit.</p> <p>Section F of the assessment contained questions about the resident's Preferences for Customary Routine and Activities. None of the questions in the section were answered.</p> <p>The Activity Care Area Assessment (CAA) and the Behavior Symptoms CAA were among the areas identified for further assessment for Resident #71.</p> <p>a.) The Activity CAA is required when the resident may have evidence of decreased involvement in social activities. Resident #71's Activity Care Area Assessment summary dated 11/20/2017 stated, "Resident is alert, oriented to self, will make very brief eye contact when name called. She has mumbled speech. She can answer questions but not aware of day or time." It also specified Resident #71 had dementia and stated, "She does have behaviors at times. Tries to fight or grab people."</p> <p>There was no individual information explaining what activities the resident enjoyed, if she was involved or withdrawn from recreational activities, or conclusions that arose from performing the CAA.</p> <p>On 06/14/2018 at 2:03 PM, the Activity Director was asked about completion of Section F on the</p> | F 636   |   |                      |   |

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| F 636   | <p>Continued From page 5</p> <p>MDS. The Activity Director stated, ""I didn't know I was supposed to ask the staff [if the resident was unable to respond]." The Activity Director offered no explanation about why the Activity CAA summary for Resident #71 did not address activity preferences and social participation.</p> <p>b.) The Behavior Symptoms CAA is required when a resident exhibits certain troubling behavioral symptoms. Resident #71's Behavior Symptoms CAA summary dated 11/20/2017 stated, "Resident is alert, oriented to self, will respond by eye contact when named called. She requires assist with ADLS (activities of daily living). She grabs out at others as they walk by." It also specified Resident #71 had dementia, was unable to complete the Cognition interview, was receiving palliative care services and was often observed sleeping.</p> <p>The CAA did not identify the frequency of the behaviors, underlying causes, contributing factors, or approaches specific to this resident to consider in developing an individualized care plan.</p> <p>On 06/14/2018 at 3:05 PM, the Social Worker indicated the CAA was supposed to be a summary of problems and how the problems were be addressed for this individual. The Social Worker stated, "I will be more detailed from now on."</p> <p>The Director of Nursing specified in an interview on 06/14/18 at 4:40 PM, it was her expectation the MDS would be complete.</p> <p>3. Resident #82 was admitted to the facility on</p> | F 636   |   |                      |   |

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| F 636   | <p>Continued From page 6</p> <p>11/04/2016 with diagnoses which included anxiety and depression.</p> <p>The annual Minimum Data Set (MDS), dated 09/29/2017, indicated the resident was severely cognitively impaired and required extensive assistance from staff for mobility on the unit.</p> <p>Section F of the assessment contained questions about the resident's Preferences for Customary Routine and Activities. None of the questions in the section were answered.</p> <p>The Activity Care Area Assessment (CAA) was among the areas identified for further assessment for Resident #82.</p> <p>The Activity CAA is required when the resident may have evidence of decreased involvement in social activities. Resident #82's Activity Care Area Assessment summary dated 09/27/2017 stated, "Resident is alert, oriented to self, will respond mostly when spoken to. She has ST (short term) and LT (long term) memory loss. Disoriented to rate and time."</p> <p>There was no individual information explaining what activities the resident enjoyed, if she was involved or withdrawn from recreational activities, or conclusions that arose from performing the CAA.</p> <p>On 06/14/2018 at 2:03 PM, the Activity Director was asked about completion of Section F on the MDS. The Activity Director stated, "I didn't know I was supposed to ask the staff [if the resident was unable to respond]." The Activity Director offered no explanation about why the Activity CAA summary for Resident #82 did not address</p> | F 636   |   |                      |   |

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| F 636   | Continued From page 7<br>activity preferences and social participation.<br><br>The Director of Nursing specified in an interview on 06/14/18 at 4:40 PM, it was her expectation the MDS would be complete.<br><br>4. Resident #99 was admitted to the facility on 6/14/2016 with diagnoses to include dementia with Lewy bodies, neuropathy and atherosclerotic heart disease.<br><br>The annual MDS dated 4/1/2018 assessed Resident #99 to be severely cognitively impaired.<br><br>Section F of the assessment contained questions about the resident's Preferences for Customary Routine and Activities. None of the questions in the section were answered.<br><br>On 06/14/2018 at 2:03 PM, the Activity Director was asked about completion of Section F on the MDS. The Activity Director stated, "I didn't know I was supposed to ask the staff [if the resident was unable to respond]." The Activity Director offered no explanation about why Section F for Resident #99 did not address activity preferences and social participation.<br><br>The Director of Nursing specified in an interview on 06/14/18 at 4:40 PM, it was her expectation the MDS would be complete. | F 636   |   |                      |   |
| F 637<br>SS=E   | Comprehensive Assessment After Significant Chg CFR(s): 483.20(b)(2)(ii)<br><br>§483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that   | F 637   |   | 7/12/18              |   |



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| F 637   | <p>Continued From page 8</p> <p>there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, observations and staff interviews, the facility failed to complete a comprehensive significant change of status Minimum Data Set (MDS) assessment for 4 out of 23 residents reviewed for significant changes (Resident #57, #25, #156 and #58).</p> <p>Findings included:</p> <p>1. Resident #57 was admitted to the facility on 11/30/2015 and most recently readmitted on 3/22/2018 with diagnoses to include multiple sclerosis, falls and epilepsy.</p> <p>The quarterly MDS assessment dated 12/20/2017 assessed Resident #57 to be cognitively intact and she required limited assistance with bed mobility and transfers, and required extensive assistance with dressing, toileting, hygiene and bathing.</p> <p>The most recent quarterly MDS dated 5/3/2018 assessed Resident #57 to be moderately cognitively impaired and she required extensive assistance with bed mobility, transfers, dressing, toileting hygiene and total assistance bathing.</p> | F 637   | <p>1. Root Cause: The members of the Interdisciplinary Team (IDT) that participate in the Minimum Data Set (MDS) process were not comparing the prior MDS to the current MDS to identify changes in the resident status. On July 2, 2018, education was completed by the lead MDS nurse with the second seat MDS nurse on appropriately reviewing for a significant change in status per the Resident Assessment Instrument (RAI) Manual. Education included the Social Services Director, Activities Director and second seat MDS nurse.</p> <p>2. What was done to correct the deficient practice?<br/>On July 2, 2018 education related to Significant Change Minimum Data Set (MDS) was provided to the Minimum Data Set Licensed Practical Nurse (MDS,LPN), Social Services, Activities Director, and the Registered Dietician. This education was provided by the Lead Minimum Data Set (MDS) Registered Nurse(RN). Significant Change in Status Assessments</p> |                      |   |

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| F 637   | <p>Continued From page 9</p> <p>The unit manager was interviewed on 6/11/20018 at 10:30 AM. She reported Resident #57 had been admitted to the hospital for a procedure and the procedure had caused her to have increased weakness, falls and seizure activity. The Unit Manager further explained that Resident #57 had a significant change in her ability to transfer and she was leaning out of the wheelchair, so the facility had put her into a geri-chair for safety and support.</p> <p>An interview was conducted with NA #1 on 6/14/2018 at 9:39 AM. NA #1 reported she was a restorative aide and Resident #57 had been recently referred to the service for transfers and lower body active range of motion. NA #1 reported Resident #57 had a significant change in her condition and required use of a hooyer lift to transfer and much more help with activities of daily living (ADL) bathing, dressing and transfers.</p> <p>An interview was conducted with NA#2 on 6/14/201 at 10:00 AM. NA #2 reported she was a restorative aide and Resident #57 had been referred to the service recently for a change in condition. NA #2 reported Resident #57 had increased shaking and hand tremors, plus weakness.</p> <p>Nurse #1 was reviewed on 6/14/2018 at 10:33 AM. Nurse #1 reported Resident #57 had a significant change and increased seizure activity. Nurse #1 further reported Resident #57 had been more independent, but in the past few months had a change in her abilities.</p> <p>An occupational therapist (OT) #1 was interviewed on 6/14/2018 at 10:54 AM. OT #1 reported Resident #57 had a significant change in</p> | F 637   | <p>were created for residents #57, #25, #156 and #58 will be completed by July 12, 2018.</p> <p>All residents are at risk for the same deficient practice. An audit of the last 30 days of current resident Omnibus Budget Reconciliation Act (OBRA) assessments was completed on July 3, 2018 to identify other residents requiring significant changes.</p> <p>3. As of July 2, 2018 and moving forward, to prevent similar situations, significant changes in status will be reviewed by the lead MDS nurse and discussed with the IDT to determine the need for a significant change in status assessment.</p> <p>4. Monitoring/systemic changes:<br/>Random audits of 3 assessments will be reviewed by the Director of Nursing and/or her designee monthly for 3 months. Results will be submitted to the Quality Assessment and Assurance (QAA) Committee for review to evaluate the need for ongoing audits after 3 months.</p> |                      |   |

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| F 637   | <p>Continued From page 10</p> <p>her abilities and had an increase in hand tremors and her ability to perform ADLs.</p> <p>Nurse #2 was interviewed on 6/14/20018 at 11:07 AM. Nurse #2 reported that Resident #57 was more dependent on staff for her care and her ability to perform ADL ' s had significantly decreased.</p> <p>The MDS coordinator was interviewed on 6/14/2018 at 2:03 PM. She reported Resident #57 ' s condition had not affected her ADL ' s and she didn ' t feel a significant change of status assessment was necessary.</p> <p>The DON was interviewed on 6/14/2018 at 4:40 PM. She reported it was her expectation the MDS were completed accurately.</p> <p>2. Resident #25 was admitted to the facility on 6/14/2016 and readmitted 1/8/2018 with diagnoses to include chronic obstructive pulmonary disease, dementia, and cardiomyopathy.</p> <p>An admission MDS assessment dated 7/22/2017 assessed Resident #25 to be cognitively intact and independent with bed mobility and personal hygiene, he required limited assistance with transfers, walking, dressing and toileting.</p> <p>The most quarterly MDS dated 4/8/2018 assessed the resident to be cognitively intact and he required limited assistance with locomotion, dressing, hygiene, and extensive assistance with bed mobility, and toileting. The assessment noted the resident was unable to walk.</p> <p>A comprehensive MDS had not been completed</p> | F 637   |   |                      |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
OMB NO. 0938-0391

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| F 637   | <p>Continued From page 11 after Resident #25 returned from the hospitalization.</p> <p>A nursing note dated 12/19/2017 documented the readmission to the facility of Resident #25. The note further documented the removal of hardware from his right ankle and a surgical wound with a dressing in place.</p> <p>A review of nursing notes revealed a note dated 12/21/2017 which documented the change in condition of the resident, fever and transfer to the hospital.</p> <p>A nursing note dated 12/30/2017 documented Resident #25 ' s readmission to the facility after hospitalization and the presence of a wound vacuum to the right lower leg.</p> <p>A nursing note date 1/9/2018 documented Resident #25 readmission to the facility and the presence of a large surgical scar from open heart surgery, the presence of a wound vacuum to the right lower leg and bruising from blood thinner injections.</p> <p>Resident #25 was interviewed on 6/12/2018 at 1:52 PM. Resident #25 reported he had been in and out of the hospital multiple times in November, December 2017 and returned to the facility in January 2018. He reported he had hardware removed from his right ankle and developed an infection, and then required open heart surgery for a heart condition. He further reported he had a change in his ability to ambulate due to the surgery.</p> <p>An interview was conducted with NA #1 on 6/14/2018 at 9:39 AM. NA #1 reported Resident</p> | F 637   |   |                      |   |

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| F 637   | <p>Continued From page 12</p> <p>#25 was seen by the restorative aides for transfers.</p> <p>NA #2 was interviewed on 6/14/2018 at 10:00 AM and she reported Resident #25 was seen by restorative aides to assist with transfers.</p> <p>OT #1 was interviewed on 6/14/2018 at 10:45 AM. She reported Resident #25 had been seen by occupational therapists many times and the last time was March 2018 after he had hardware removed from his right ankle. She reported Resident #25 was seen by occupational therapy for safety, transfer assistance and dressing due to non-weight bearing status of his right leg.</p> <p>OT #2 was interviewed on 6/14/2018 at 10:59 AM. She reported she had seen Resident #25 for occupational therapy after hardware removal from his foot. She reported the resident had pain related to the surgery and was unable to bear weight on the right leg.</p> <p>Nurse #2 was interviewed on 6/14/2018 at 11:07 AM. She reported the resident had surgery and this affected his ability to walk. She further reported Resident #25 required more aide assistance than before surgery.</p> <p>The MDS coordinator was interviewed on 6/14/2018 at 2:03 PM. She reported did not complete a significant change of status MDS assessment for Resident #25 because Resident #25 required the same level of care before and after the hardware removal from his right ankle.</p> <p>The Director of Nursing (DON) was interviewed on 6/14/2018 at 4:40 PM. She reported it was her expectation the MDS were completed accurately.</p> | F 637   |   |                      |   |

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| F 637   | Continued From page 13<br><br>3. Resident # 156 was admitted to the facility on 01/03/2018 and readmitted to the facility on 02/09/2018. Cumulative diagnoses included Cerebral Palsy (CP), quadriplegia, kidney calculus, history of urinary tract infection (UTI) and scrotal mass.<br><br>A comprehensive Minimum Data Set (MDS) dated 01/10/2018 coded Resident #156 as unable to complete the review for the cognitive patterns at C0500 and was coded a 99 unable to complete the Brief Interview for Mental Status, BIMS). A dash was coded in the section C0600 and section C0700 for short and long - term memory impairment and 0800 was coded with dashes for cognitive skills for daily decision making. Section D0100 was coded a zero. A staff assessment of Resident Mood (PHQ-9-OV) revealed at D0500 A to J that Resident # 156 had no mood presence or symptom frequency and scored a 00 on D0600. Resident # 156 was coded as he required 1 person physical assist during transfers (G0110B), and had no locomotion on or off the unit during the review period (G0110E and G0110F.) Resident # 156 was coded to weigh 85 pounds and had no weight loss and no weight gain.<br><br>A review of a quarterly MDS dated 04/09/2018 revealed that Resident # 156 had a BIMS score of 99 at C0500. Resident # 156 was coded a 1 at C0600 which indicated that Resident # 156 was unable to complete the BIMS) and dashes were placed on C0700 and C0800 for both short term and long- term memory impairment. D0100 was coded as 1 and to continue to D0200 and OD0300. On D0200 A through I, Resident # 156 | F 637   |   |                      |   |

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| F 637   | <p>Continued From page 14</p> <p>was coded as 9 (no response) and D0300 Total Severity Score was coded as a 99, unable to complete interview. Section D at D0500 revealed that Resident # 156 had feelings of or appeared down, depressed, or helpless for 2 to 6 days of the review period and D0500D, Resident # 156 felt tired or had little energy on 2 to 6 days of the review period. Resident # 156 scored a 02 on D0600. Resident # 156 was coded at G0110B to need 2 plus person physical assist for transfers and was coded total dependence (4) for self-performance and 2 (1 person physical assist for locomotion on and off the unit). Resident # 156's weight was recorded as 83 pounds and at K0300 was coded as a weight loss and not on a physician prescribed weight-loss program.</p> <p>An interview conducted on 06/14/2018 at 2:03 PM was with the RN (Registered Nurse) MDS coordinator and revealed that the quarterly MDS dated 05/04/2018 did have coding differences from the annual MDS of Resident # 156 and that a comparison of the MDSs should have been completed to determine the changes in status of Resident # 156 and a significant change in status MDS should have been completed for Resident # 156 instead of a quarterly MDS.</p> <p>On 06/14/2018 at 4:04 PM an interview was conducted with the Director of nurses (DON) revealed that the expectation was that members of the interdisciplinary Care Plan Team (ICP Team) follow the guidelines of the Resident Assessment Instrument (RAI) in completion of all MDS assessments and that each team member was responsible for accuracy coded on each MDS and it was expected that a significant change in status be completed within 14 days of the significant change as directed by the RAI.</p> | F 637   |   |                      |   |

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| F 637   | <p>Continued From page 15</p> <p>4. Resident # 58 was admitted to the facility on 12/27/2016 with diagnoses that included dementia with behavioral disturbance, hypertension (HTN), urinary incontinence, feces incontinence, gait and mobility abnormalities, dysphagia, and depression.</p> <p>A review of a significant change in status MDS dated 02/08/2018 revealed that Resident # 58 was coded at B0800 as (2) sometimes understands. Resident # 58 was coded as 1 at C0200 and was coded with a BIMS score of 01, significantly cognitively impaired. Resident # 58 was coded at C0600 with a zero and coded at C1310 B and C as inattention and disorganized thinking present and fluctuating. Resident # 58 was coded as no locomotion off the unit. J0100 B was coded that Resident #58 received no as needed (prn) pain medication. Resident # 58 was coded with no indicators of pain or possible pain. Resident # 58 was coded with a weight of 96 pounds.</p> <p>A review of a quarterly MDS dated 05/04/2018 was reviewed and revealed at B0700, Resident # 58 was coded as 2, sometimes understood, and 3 at B0800 rarely/ never understood. Resident # 58 was coded with a BIMS Score of 99. On C0600 Resident # 58 was coded with a 1, and had both short - term and long - term memory impairment with poor cognitive skills for daily decision making per staff interview of C0700 through C1000. C1310 B and D were coded as zero and a dash was in C1310 C. Resident # 58 was coded as total dependence of at least 1 person for off unit locomotion. J0100 B was coded that Resident # 58 received prn pain medication or was offered and declined prn pain</p> | F 637   |   |                      |   |



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| F 637   | Continued From page 16<br>medication and no signs were observed or documented that Resident #58 had indicators or possible pain in the review period. Resident # 58 was coded with facial expressions as indicators of pain or possible pain. Resident # 58 was coded with a weight of 100 pounds and was not a physician - prescribed weight gain program.<br><br>An interview conducted on 06/14/2018 at 2:03 PM was conducted with the RN (Registered Nurse) MDS coordinator and revealed that the quarterly MDS dated 05/04/2018 did have coding differences from the annual MDS of Resident # 58 and that a comparison of the MDSs should have been completed to determine the changes in status of Resident # 58 and a significant change in status MDS should have been completed for Resident #58 instead of a quarterly MDS.<br><br>On 06/14/2018 at 4:04 PM an interview was conducted with the Director of nurses (DON) and revealed that the expectation was that members of the interdisciplinary Care Plan Team (ICP Team) follow the guidelines of the Resident Assessment Instrument (RAI) in completion of all MDS assessments and that each team member was responsible for accuracy coded on each MDS and it was expected that a significant change in status be completed within 14 days of the significant change as directed by the RAI. | F 637   |   |                      |   |
| F 641<br>SS=D   | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced   | F 641   |   | 7/12/18              |   |

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| F 641   | <p>Continued From page 17</p> <p>by:<br/>Based on record review and staff interviews, the facility failed to accurately code Minimum Data Set (MDS) assessments for 1 out of 23 residents reviewed for MDS accuracy (Resident #84).</p> <p>Findings included:</p> <p>1. Resident #84 was admitted to the facility on 11/2/2016 with diagnoses to include dementia with behavioral disturbance, high blood pressure and difficulty swallowing.</p> <p>A pharmacy note dated 2/23/2018 documented a gradual dose reduction (GDR) for the medication Zyprexa (antipsychotic) on 1/30/2018.</p> <p>The quarterly MDS dated 5/18/2018 assessed him to be severely cognitively impaired. Section N question 0450 was answered "yes-antipsychotics prescribed" and "B. No GDR attempted.</p> <p>The MDS coordinator was interviewed on 6/14/2018 at 2:03 PM. She reported she was not certain why the GDR was not coded on the MDS.</p> <p>The Director of Nursing (DON) was interviewed on 6/14/2018 at 4:40 PM. She reported it was her expectation the MDS were completed accurately.</p> | F 641   | <p>1. Root Cause: The second seat MDS nurse was not reviewing the gradual dose reduction (GDR) paperwork from the pharmacy.</p> <p>2. What was done to correct deficient practice? On July 2, 2018, education was provided by the Lead Minimum Data Set Registered Nurse to the second seat Minimum Data Set Licensed Practical Nurse (MDS,LPN) nurse on coding Gradual Dose Reductions(GDR). The Minimum Data Set(MDS)assessment for resident #84 with the error was modified on July 2, 2018 to correctly reflect the Gradual Dose Reduction (GDR). On July 2, 2018, an audit of the last 30 days of the Omnibus Budget Reconciliation Act(OBRA) assessments for current residents were reviewed by the Lead Minimum Data Set (MDS)Registered Nurse (RN) for accurate coding of Gradual Dose Reduction (GDR). No other assessments were noted to be affected.</p> <p>3. Measures/systems implement to ensure the problem does not reoccur: As of July 2, 2018 and moving forward the Lead Minimum Data Set(MDS)Registered Nurse (RN)will review the Omnibus Budget Reconciliation Act (OBRA) assessments and cross-reference the pharmacy dose reduction report to ensure accuracy prior to submission to CMS.</p> <p>4. Monitoring: A random audit of 10 Omnibus Budget Reconciliation Act</p> |                      |   |

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| F 641   | Continued From page 18   | F 641   | (OBRA) assessments will be completed by the Director of Nursing and/or her designee monthly for 3 months. This number is based on the number of Omnibus Budget Reconciliation Act(OBRA) assessments completed by the facility on a monthly basis. Results will be submitted to the Quality Assurance and Assessment(QAA) Committee to evaluate the need for ongoing audits after the 3 months. |                      |   |
| F 642<br>SS=D   | Coordination/Certification of Assessment<br>CFR(s): 483.20(h)-(j)<br><br>§483.20(h) Coordination.<br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>§483.20(i) Certification.<br>§483.20(i)(1) A registered nurse must sign and certify that the assessment is completed.<br><br>§483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>§483.20(j) Penalty for Falsification.<br>§483.20(j)(1)Under Medicare and Medicaid, an individual who willfully and knowingly-<br>(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or<br>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment. | F 642   |  | 7/12/18              |   |

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| F 642   | <p>Continued From page 19</p> <p>§483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interviews, the facility failed to ensure that the comprehensive minimum data set (MDS) assessments were complete before submitting the assessments to the national database for 4 of 22 residents (Residents #71, #82, #73, and #99.) The findings included:</p> <p>1. Resident #71 was admitted to the facility on 06/03/2010 with diagnoses which included anxiety and depression.</p> <p>The significant change in status Minimum Data Set (MDS), dated 11/16/2017, indicated the resident was severely cognitively impaired.</p> <p>Section F of the assessment contained questions about the resident's Preferences for Customary Routine and Activities. None of the questions in the section were answered.</p> <p>The MDS of 11/16/2017 was signed by the MDS Coordinator as complete on 11/30/2017 and was submitted to the national database as complete on 12/01/2017.</p> <p>During an interview on 06/14/2018 at 2:26 PM, the MDS Coordinator indicated she had overlooked the completion of Section F and understood that her signature on the assessment indicated it was complete.</p> <p>The Director of Nursing stated in an interview on 06/14/2018 at 4:40 PM, it was her expectation the</p> | F 642   | <p>1. Root Cause: The MDS RN lead was signing to the completion of the MDS in section Z0500 when the MDS was not complete because she was not aware that she needed to review all sections of the MDS to ensure they were complete prior to signing.</p> <p>2. What was done to correct deficient practice? On July 2, 2018 education was provided to the MDS RN lead by the CPA (Clinical Process Analyst) on section Z0500 of the MDS. Significant Corrections to Prior Comprehensive assessment MDS's were created for residents #73,#71, #82 and #99 and will be completed by July 12, 2018. All residents are at risk for the same deficient practice.</p> <p>3. Systemic Changes: As of July 2, 2018 and moving forward Brief Interview for Mental status (BIM's), Mood Interview, Activity Preference Interview and Care Area Assessments (CAA's) completed by the Activity Director and Social Services Director will be reviewed by the Lead Minimum Data Set(MDS)Registered Nurse (RN) for completion prior to submission to Centers for Medicare and Medicare Services (CMS).</p> <p>4. A random audit of 3 Minimum Data Set(MDS) assessments will be reviewed</p> |                      |   |

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| F 642   | <p>Continued From page 20</p> <p>MDS would be complete before the MDS Coordinator signed and transmitted the MDS to the national database.</p> <p>2. Resident #82 was admitted to the facility on 11/04/2016 with diagnoses which included anxiety and depression.</p> <p>The annual Minimum Data Set (MDS), dated 09/29/2017, indicated the resident was severely cognitively impaired.</p> <p>Section F of the assessment contained questions about the resident's Preferences for Customary Routine and Activities. None of the questions in the section were answered.</p> <p>The MDS of 09/29/2017 was signed by the MDS Coordinator as complete on 10/11/2017 and was submitted to the national database as complete on 10/11/2017.</p> <p>During an interview on 06/14/2018 at 2:26 PM, the MDS Coordinator indicated she had overlooked the completion of Section F and understood that her signature on the assessment indicated it was complete.</p> <p>The Director of Nursing stated in an interview on 06/14/2018 at 4:40 PM, it was her expectation the MDS would be complete before the MDS Coordinator signed and transmitted the MDS to the national database.</p> | F 642   | <p>by the Director of Nursing and/or her designee monthly for 3 months. The designee will be the Clinical Process Analyst.</p> <p>Results will be submitted to and reviewed by the Quality Assurance and Assessment (QAA) Committee to determine the need for ongoing audits after 3 months.</p> |                      |   |

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| F 642   | <p>Continued From page 21</p> <p>3. Resident # 73 was admitted to the facility on 11/10/2017 with diagnoses which included impaired communication and vascular dementia.</p> <p>A. The admission MDS dated 11/22/2017 had sections not completed which included:</p> <ol style="list-style-type: none"> <li>1. Section C of the assessment that contained questions about the resident's Cognitive Patterns. The brief interview for mental status (BIMS), staff assessment for mental status and confusion assessment method (CAM) questions were not answered.</li> <li>2. Section F of the assessment contained questions about the resident's Preferences for Customary Routine and Activities. None of the questions were answered.</li> <li>3. The MDS was signed as complete on 11/22/2017 and submitted to the national database as complete on 11/28/2017.</li> </ol> <p>B. The significant change in status MDS dated 2/9/2018 had sections not completed which included:</p> <ol style="list-style-type: none"> <li>1. Section C of the assessment contained questions about the resident's Cognitive Patterns. The staff assessment for mental status questions were not answered.</li> <li>2. Section F of the assessment contained questions about the resident's Preferences for Customary Routine and Activities. None of the questions were answered.</li> <li>3. The MDS was signed as complete on 2/9/2018 and submitted to the national database as complete on 2/26/2018.</li> </ol> <p>An interview with the MDS nurse on 6/14/2018 at 2:26 pm revealed she had overlooked the</p> | F 642   |   |                      |   |

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| F 642   | Continued From page 22<br>completion of the MDS and understood her signature on the assessment indicated it was complete.<br><br>An interview with the DON on 6/14/2018 at 4:40 pm revealed she expected the MDS to be completed by each member of the interdisciplinary team before the MDS nurse signed and transmitted.<br>4. Resident #99 was admitted to the facility on 6/14/2016 with diagnoses to include dementia with Lewy bodies, neuropathy and atherosclerotic heart disease.<br><br>The annual MDS dated 4/1/2018 assessed Resident #99 to be severely cognitively impaired.<br><br>Section F of the assessment contained questions about the resident's Preferences for Customary Routine and Activities. None of the questions in the section were answered.<br><br>During an interview on 06/14/2018 at 2:26 PM, the MDS Coordinator indicated she had overlooked the completion of Section F and understood that her signature on the assessment indicated it was complete.<br><br>The Director of Nursing stated in an interview on 06/14/2018 at 4:40 PM, it was her expectation the MDS would be complete before the MDS Coordinator signed and transmitted the MDS to the national database. | F 642   |   |                      |   |
| F 679<br>SS=D   | Activities Meet Interest/Needs Each Resident<br>CFR(s): 483.24(c)(1)<br><br>§483.24(c) Activities.<br>§483.24(c)(1) The facility must provide, based on  | F 679   |   | 7/12/18              |   |

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| F 679   | <p>Continued From page 23</p> <p>the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, observations and staff interviews, the facility failed to provide an ongoing activities program which met the individual interests and needs for 2 of 2 residents reviewed for activities (Resident #70 and #102).</p> <p>Findings included:</p> <p>1. Resident #70 was admitted to the facility on 5/1/2014 and the most recent readmission was 7/19/2017. Diagnoses for Resident #70 included chronic obstruction pulmonary disease, diabetes and hypertension.</p> <p>Review of Resident #70 ' s current care plan, most recently revised by staff on 6/1/2017, revealed it addressed the resident ' s need for 1:1 visits with the activities department, assistance to and from activities by the nursing assistant staff, and her preferred activities were bingo and socials with the activity department. The care plan goal was revised on 10/3/2017 and had a goal date of 5/10/2018.</p> <p>The annual Minimum Data Set (MDS) dated 7/20/2017 assessed the resident to be severely cognitively impaired. Resident #70 ' s preferred activities were reading books, newspapers and</p> | F 679   | <p>Residents #70 and #102 care plans for on-going activities program did not meet their individualized needs based on the cognitive status reflected on each resident's most current Minimum Data Set (MDS) assessment. It was determined that the social service and activity interdisciplinary team members were not always reviewing the assessments and care plans as a team, therefore leaving the care plan at risk for not being an accurate reflection of the residents' activity programming needs.</p> <p>1. Education was provided by the Lead Minimum Data Set (MDS)Registered Nurse (RN) and/or his or her designee to the social service and activity interdisciplinary care planning team members on July 2nd, regarding reviewing the Minimum Data Set (MDS) assessment as a team and applying the information in an interdisciplinary approach during the care planning process to create care plans that meet the individualized needs of residents as it relates to activities.</p> |                      |   |



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| F 679   | <p>Continued From page 24</p> <p>magazines, participate in favorite activities, listen to music, go outside when the weather is nice and participate in religious services. The MDS indicated these activities were somewhat important to the resident.</p> <p>The most recent quarterly MDS dated 5/8/2018 assessed the resident to be severely cognitively impaired.</p> <p>Review of Resident #70 ' s activities task documentation for the month of June 2018 revealed the resident had only participated in one type of activity, which was conversation/talking. The activity was documented on 6/9/2018 and on 6/13/2018. During the month of May 2018, the resident participated in conversation/talking 21 days out of 31 days.</p> <p>Resident #70 was observed sleeping in her bed on 6/11/2018 at 3:02 PM. She was alone in the room.</p> <p>Activities for 6/11-14/2018 were observed and Resident #70 was not observed participating in the activities.</p> <p>An observation of Resident #70 on 6/12/2018 at 9:24 AM revealed the resident was sleeping with her TV on and was alone in her room.</p> <p>The resident was observed on 6/12/2018 at 2:49 PM sleeping in her bed and was alone in her room.</p> <p>The resident was observed on 6/13/2018 at 9:48 AM sleeping in her bed with the TV on, but the remote was on the dresser across the room. Resident #70 was alone in her room.</p> | F 679   | <p>2. All residents are at risk for the same deficient practice. The activities programs for Residents #70 and #102 have been reviewed and modified to meet the individual needs of these residents. Information was derived from interviews with both the residents and their families focusing on both past and current interests and needs. The care plans and MDS for these residents have been updated to reflect these changes. On or by July 12th, 2018, a complete audit of resident activity care plans for those evaluated as severely cognitively impaired (according to the most current completed MDS) will be conducted by the Activities Director to validate that the activities programming meet the needs of the residents.</p> <p>3. As of July 12th and going forward, a random audit of 8 residents identified on the minimum data set (MDS) assessment as severely cognitively impaired will be reviewed by the Lead Minimum Data Set (MDS) Registered Nurse (RN) and/or her designee weekly for 4 weeks, to monitor and ensure that the ongoing activity programming care plans meet the needs of severely cognitively impaired residents.</p> <p>5. Results from the audit will be tracked and trended by the Activities Director and reported to the Quality Assurance and Assessment (QAA) Committee. The committee will review and make recommendations to assure that compliance is ongoing and to determine the need for further auditing.</p> |                      |   |

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| F 679   | <p>Continued From page 25</p> <p>Resident #70 was observed on 6/14/2018 at 12:00 PM sleeping in her bed. The resident was alone in her room.</p> <p>Nurse #2 was interviewed on 6/14/2018 at 11:07 AM. Nurse #2 reported the resident had a recent decline in her condition, but Resident #70 was still waking for meals and feeding herself.</p> <p>The Activities Director (AD) was interviewed on 6/14/2018 at 2:03 PM. She reported she did not realize how little the resident was receiving 1:1 interactions until she printed out the activities task documentation.</p> <p>2. Resident #102 was admitted to the facility on 6/13/2017 with diagnoses to include Alzheimer ' s disease, hypertension and emphysema. The most recent annual MDS dated 5/20/2018 assessed the resident to be severely cognitively impaired. The MDS specified activities that were somewhat important to him included listening to music and keeping up with the news.</p> <p>The Care Area Summary from the 5/20/2018 MDS did not trigger activities care area. The activities task documentation for June 2018 was reviewed for Resident #102. The last documented interaction with Resident #102 dated 6/9/2018 at 1:16 PM "conversation/talking" and the task had been documented 5 times in June 2018, and 21 out of 31 days in May 2018. One to one visits were documented 2 times in April 2018, 1 time in May 2018 and not documented in June 2018. The activity, music was documented as "refused/not applicable/not available" five times in May 2018.</p> <p>Resident #102 was observed on 6/11/2018 at</p> | F 679   |   |                      |   |

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| F 679   | Continued From page 26<br>10:03 AM. He was in bed watching TV.<br><br>An observation of Resident #102 was completed on 6/11/2018 at 2:55 PM. He was in bed and watching TV.<br><br>Resident #102 was observed on 6/12/2018 at 8:54 AM. He was in bed and watching TV.<br><br>Resident #102 was interviewed on 6/12/2018 at 8:54 AM. He reported he would get out of bed "sometimes". He further reported he liked the TV station he was watching because they played games.<br><br>Nursing assistant (NA) #1 was interviewed on 6/14/2018 at 9:39 AM. She reported she had provided care for Resident #102 in the past and he would get out of bed for activities infrequently. NA #1 was not able to report the activities that Resident #102 preferred.<br><br>Nurse #1 was interviewed on 6/14/2018 at 10:36 AM. She reported Resident #102 did not get out of bed to go to activities and the activities department would visit him in his room.<br><br>The Activities Director (AD) was interviewed on 6/14/2018 at 2:03 PM. She reported she did not realize how little activity Resident #102 was receiving 1:1 interactions until she printed out the activities task documentation. | F 679   |   |                      |   |
| F 812<br>SS=F   | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -   | F 812   |   | 7/12/18              |   |

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| F 812   | <p>Continued From page 27</p> <p>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.</p> <p>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.</p> <p>(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.</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations and staff interviews, the facility failed to store raw meat in drip-proof containers to prevent blood and meat juices from dripping onto a cardboard box with uncooked meat stored in it, this was observed for 1 of 2 observations of the kitchen 's walk-in refrigerator.</p> <p>Findings included:</p> <p>The kitchen was observed on 6/11/2018 at 9:27 AM. The walk-in refrigerator was observed to have a large raw pork roast sitting on a box in the middle of the refrigerator. The box was sitting on a shelving rack that was elevated off the floor. Milk crates with individual milk cartons were stacked beside the raw meat. The pork roast was resting in a pool of blood that had collected on the top of the box. No blood was noted to have leaked into the cardboard box or onto the milk cartons stacked beside the raw meat.</p> | F 812   | <p>1. Root Cause: It was determined that this was an isolated incident. However, it is felt that not every Nutritional Services staff member understood the importance of ensuring food is properly stored. Education was provided to the Nutritional Services staff by the Registered Dietician and Nutritional Services Manager on June 12, 2018 regarding food storage.</p> <p>2. The thawing meat was moved to the proper storage location in the walk-in refrigerator immediately upon notification. All other items in both the walk-in refrigerator and the reach-in refrigerator were checked and were being stored properly.</p> <p>3. A refrigerator audit tool has been implemented to check for the proper thawing of meats. The refrigerators will</p> |                      |   |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>MONROE REHABILITATION CENTER</b> |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1212 SUNSET DRIVE EAST</b><br><b>MONROE, NC 28112</b>   |                      |   |
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| F 812   | <p>Continued From page 28</p> <p>The Dietary Aide (DA) #1 was interviewed on 6/11/2018 9:27 AM. She reported the raw pork roast should not be thawing on top of a box and should be on a drip-proof tray on the bottom shelf of the refrigerator. DA #1 reported she had not noticed the pork roast was not in a drip-proof pan and was thawing in the middle of the refrigerator on top of a box. DA #1 reported the raw meat should have been placed in a drip-proof container and placed on the bottom, right side of the refrigerator.</p> <p>An interview was conducted with the Dietary Manager (DM) on 6/12/2018 at 10:47 AM. The DM reported she was not working on 6/11/2018 and was not certain who put the pork roast into the refrigerator to thaw and did not put it into a drip-proof pan.</p> <p>DA #3 was interviewed on 6/12/2018 at 2:13 PM. DA #3 reported she was assigned to cook on 6/10/2018. DA #3 reported she had not taken the raw pork roast out of the freezer to thaw, but she had entered the walk-in refrigerator on 6/10/2018 at about 1:30 PM to obtain meat to cook for dinner on 6/10/2018. She further reported that the pork roast was sitting on a box on the bottom shelf and she moved the box and the pork roast out of the way and placed the box on the rack and the pork roast on top of the box. DA #3 explained that raw meat should be placed in a drip-proof container and placed on the bottom right-hand shelf of the refrigerator. She concluded by reporting that she forgot about the pork roast thawing on the cardboard box.</p> <p>DA #1 was interviewed on 6/13/2018 at 12:45 PM. She reported she had been in and out of the walk-in refrigerator on 6/11/2018 multiple times,</p> | F 812   | <p>be checked twice a day by Nutritional Services staff and once each week by the Registered Dietician/Nutritional Services Manager and/or her designee. These audits will continue for 60 days or until there is proper storage for 60 consecutive days.</p> <p>This information will be monitored in the QA Committee for 2 months unless determined otherwise by this committee.</p> |                      |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                        |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>345254</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>06/14/2018</b> |
|---|---|---|---|----------------------|---|
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| F 812   | Continued From page 29<br>but she had not noticed the pork roast thawing on the cardboard box.<br><br>DA #2 was interviewed on 6/14/2018 at 8:13 AM. She reported she was working 6/11/2018 and had entered the walk-in refrigerator at least twice to obtain food to cook for breakfast, but she had not noticed the pork roast thawing on the cardboard box.<br><br>The DM was interviewed on 6/14/2018 at 3:39 PM. She reported staff were trained to put raw meat into drip-proof containers and placed on the bottom shelves of the refrigerator on the right-hand side. The DM reported it was her expectation that frozen foods were thawed correctly. | F 812   |   |                      |   |