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WINSTON SALEM NURSING & REHABILITATION CENTER	1900 W 1ST STREET WINSTON-SALEM, NC 27104

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E 001 SS=E	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop an Emergency Preparedness (EP) plan. The EP plan did not address the resident population to include residents at risk, the subsistence needs of residents and staff, procedures for tracking residents and staff, the use of volunteers in an emergency situation, the role of the facility using a waiver declared by the Secretary, a method of sharing information with resident ' s families / representatives regarding the EP plan and	E 001	E001 I. Facility failed to develop an emergency preparedness plan based on newly hired administration for the Administrator and Director of Nurses. The Emergency Program which consists of a plan to identify and analyze the facility□s resident population and identify the personnel, physical plant, environmental and emergency response resources to	9/20/18

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

Electronically Signed | 09/13/2018

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E 001	Continued From page 1 develop testing exercises that included a second full-scale exercise that was community or facility based and a tabletop exercise with analysis. Findings included: Review of the facility ' s Emergency Preparedness plan materials revealed: A. The EP plan did not address the resident population including at risk residents and the type of services the facility could provide in an emergency. B. The EP plan did not address the subsistence needs of the residents and staff during an emergency. C. The EP plan did not address a procedure for tracking residents and on-duty staff if evacuated during an emergency. D. The EP plan did not address the role of volunteers during an emergency. E. The EP plan did not contain the role of the facility using a waiver declared by the Secretary, in accordance with section 1135 of the Act. F. The EP plan did not identify a method of sharing the EP plan with the resident ' s and family representatives. G. The EP plan testing exercises did not include a second full-scale exercise that was community or facility based and did not include a tabletop	E 001	needed to competently care for the residents during normal operations and emergencies. This plan was revised on 9-10-18 by Administrator to include the following: *Residents at risk *The minimum levels (Subsistence) needed of residents and staff *Procedures of tracking residents and staff *The use of volunteers in emergency situations *Role of the facility in using a waiver declared by the NC Secretary *Method(s) of sharing information with resident□s families regarding the EP Plan *Develop testing exercises that includes a full-scale exercise that is community or facility based and a table exercise with analysis. II. The facility completed a full-scale exercise on 6/19/18 and 6/23/18 (Tornado Exercise). Facility followed up with a Table Top Exercise to further discuss simulated emergency situations. The facility wide assessment tool was initiated and completed to determine the specific needs of the facility. As a result of the data collected from the Facility Assessment Tool, the Emergency Program was revised to meet the specificity of residents, employees, and volunteers needs pertaining to emergencies. Departmental new hires will be educated to the Emergency Plan via the Administrator.	

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E 001	Continued From page 2 exercise with analysis. An interview on 8/23/18 at 8:45 pm with the Administrator revealed the facility EP plan was still a work in process.	E 001	III. The Emergency Program will be reviewed at least quarterly x 1 year during facility□s QAPI (Quality Assurance Performance Improvement Meeting) to assure compliance. Thereafter, the Emergency Program will be reviewed at a minimum of annually. IV. Administrator will be responsible for overall compliance. Data results will be reviewed and analyzed at the centers monthly QAPI meeting with a subsequent POC as needed	
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		9/20/18

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F 550	Continued From page 3 §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 observations, record review, and staff resident and family interviews, the facility failed to provide incontinence care on 3 out of 4 residents (Resident #25, Resident #2, Resident #122, Resident #72) when the residents rang the call bell, sometimes waiting up to nine hours. The facility failed to provide bed pans when needed on 2 out of 2 residents (Resident #122, Resident #72) who had episodes of continence. Findings include: 1. Resident # 25 was admitted to the facility on 1/24/18 with heart failure, diabetes mellitus, left below the knee amputation, and depression. A review of Resident #25's most recent MDS (Minimum Data Set) dated 5/4/18 was coded as a quarterly assessment. The MDS revealed Resident was with little cognitive impairment. Active diagnoses included heart failure, diabetes mellitus, left below the knee amputation, and	F 550	I. Based on resident interviews, the facility failed to provide timely incontinence care to Resident #25, Resident #122, Resident #72 and Resident #2 when they rang their call bells. Also, the facility failed to provide bed pans when needed for Resident #122 and Resident #72. II. Education was provided from 09/15/18 - 09/19/18 by the Director of Nursing (DON) or Assistant Director of Nursing (ADON) related to ensuring timely incontinence care is provided and ensuring residents who request to toilet are provided the means to do so. Also, education was provided to nursing staff on call bell response time. Newly hired nursing staff will be provided education by the Staff Development Coordinator during	

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F 550	Continued From page 4 generalized weakness. The MDS revealed Resident #25 required extensive two person assistance in bed mobility and transferring and extensive one person assistance with bathing and dressing. An interview with Resident #25 was conducted on 8/30/18 at 11:27am. He reported he has had to wait from 4:30pm until 10:00pm to have his brief changed when it was soaked with urine or stool. He stated it made him feel like he wasn't important to the staff. Another interview was conducted with Resident #25 on 8/22/18 at 3:45pm. The resident reported he called to have his brief changed at 2:50pm due to having had a bowel movement and no one had come to change him. He reported he was told he would have to wait because the staff was in shift change. He reported he was frustrated when no one helped him. He reported that he missed the dance activity downstairs this afternoon because he was soiled and no one had changed him. Resident #25 reported he waited from 6:30am until 10:30am this am to be gotten up and changed and almost missed the lunch outing. Revisited Resident #25 at 4:55pm on 8/22/18 and he had just had his brief changed. An interview was conducted with NA #6 (Nursing Assistant) on 8/22/18 at 5:00pm. NA #6 reported she checks on incontinent residents every 2 hours and sooner on the residents that soil their briefs more often. She reported she attempts to answer call light quickly and does not leave any one wet for any periods of time. She reported she sometimes came on her shift and residents had not been changed prior to shift change so she tried to get to them first. 2. Resident #2 was admitted to the facility on 7/10/17 with dementia, mood disorder, and	F 550	their orientation period on ensuring timely incontinence care is provided, ensuring residents who request to toilet are provided the means to do so and call bell response. Any nursing staff not completing education by 09/24/18 will be removed from the schedule until education is completed. III. On 9/23/18, Call bell audits were initiated by the Unit Manager (UM), DON and ADON. These audits will be conducted daily for two (2) weeks, three times weekly for six (6) weeks then weekly for four (4) weeks. These audits will be conducted across all shifts including weekends. On 9/23/18, Call bell response time questionaries and Toileting questionnaires were initiated by the DON, ADON and UM. These questionnaires will be completed with fifteen (15) residents weekly for twelve (12) weeks to ensure timeliness of call bell response and assuring residents who are able and request to toilet are provided the means to do so with use of assistive devices such as bed pans. Monthly for a minimum of three (3) months, the Director will report completed audit results to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	

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F 550	Continued From page 5 bipolar disease. A review of Resident #2's most recent MDS dated 6/4/18 and coded as a quarterly assessment revealed the resident is cognitively impaired. Resident #2's MDS coded the resident as needing extensive one person assistance with bed mobility, extensive two person assistance with transfers, and total dependence in bathing and dressing. Resident #2 was coded as incontinent of bowel and had a suprapubic catheter. An interview was conducted with Resident #2's family member on 8/21/18 at 2:08pm. She reported that when she came to the facility on the morning of 8/18/18, the resident was still in the same clothes as he was wearing the evening of 8/17/18 and there was a discolored, wet stain on the bed sheets. She reported Resident #2's catheter was also leaking. She reported when she arrived at the facility today at lunchtime, Resident #2 was laying in stool and she reported she ended up changing him because she could not find any one to clean him and change his brief. She reported Resident #2 became agitated when he is left in a soiled brief. She reported she was angry that Resident #2 is not being cared for timely. 3. Resident #72 was admitted to the facility on 6/17/18 with diagnoses that included arthritis, chronic obstructive pulmonary disease, depression and conversion disorder. A review of Resident #72's medical record revealed an elimination assessment dated 6/17/18 that coded the resident as voiding appropriately at least daily without incontinence and incontinent of stool 1-3 times weekly A review of Resident #72's most recent MDS dated 6/26/18 and coded as an admission	F 550	IV. Director of Nursing will be responsible for overall compliance. Data results will be reviewed and analyzed at the centers monthly QAPI meeting with a subsequent POC as needed.	

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assessment revealed the resident had mild cognitive impairment. The resident was coded as incontinent all the time of bladder and bowel. Active diagnoses included anemia, arthritis, depression, chronic obstructive pulmonary disease, and conversion disorder.
A review of Resident #72's care plan dated 6/26/18 revealed the resident was care planned for incontinence.
An interview with Resident #72 was conducted on 8/19/18 at 6:18pm. She reported the night of 8/18/18 she was left in a wet brief from 12:30am until 9:30am. She reported she felt embarrassed and upset that no one help her. Resident #72's roommate who is mildly cognitively impaired was present during the interview and agreed the resident had to wait all night until she was changed. Resident #72 also reported she could tell at times when she needed to use the bed pan, but when she had asked for the bed pan, the staff told her to just use her briefs. She reported being told this made her feel frustrated and hopeless with getting better and she stopped asking for the bedpan.
A telephone interview was conducted on 8/19/19 at 7:00pm with Resident #72's family member. He reported on several occasions, he had arrived at the facility to find Resident #72 wearing a wet or soiled brief.
An interview was conducted with Nurse #8 on 8/23/18 at 3:24pm. She reported when Resident #72 was first admitted to the floor, she would call out and use the bed pan at times. She reported she had incontinent episodes but also used the bedpan. She reported she didn't know why the resident didn't ask for the bedpan any more.
An interview was conducted with Nurse #9 on 8/23/18 at 3:30pm. She reported she did not know Resident #72 was able to use the bed pan.

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She reported any resident that is able to realize when he/she needed to use the bed pan, the staff needed to give the resident the bed pan and start the resident on a bladder/bowel program.
An interview was conducted on 8/23/18 at 8:00pm with the DON (Director of Nursing) and the Administrator. The DON reported it was her expectation that no resident be left waiting over 30 minutes to have his/her brief changed. She and the Administrator also reported that if a resident is able to know when to use a bed pan, then the resident should be given the bedpan instead told to use a brief.

5. Resident #122 was admitted to the facility on 7/23/18 and diagnoses included lymphedema, obesity, diabetes, lack of coordination and muscle weakness.

An admission minimum data set (MDS) dated 7/30/18 for Resident #122 revealed she was always incontinent of bowel and bladder, required extensive two-person assist with toilet use and her cognition was intact.

Review of the medical record revealed no care plans had been developed for Resident #122.

An interview on 8/19/18 at 3:34 pm with Resident #122 revealed she knew when she needed to go to the bathroom and preferred to use the bed pan. She stated when she needed to have a bowel movement she would turn on her call light to request the bed pan. She explained when the staff did respond to her call light they would tell her to have the bowel movement in her brief and then they would come back and clean her up. Resident #122 added the staff told her they would

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rather have her have a bowel movement in her brief then in the bed pan because if she had loose stools it would splatter and make a mess on her sheets and then they would have to change her sheets as well as clean her up. She stated she didn ' t feel like she had a choice but to have a bowel movement in her brief and then had to sit in it until the staff came back to clean her up. She explained it was often 30 minutes or more that she had to sit in her own stool which made her feel uncomfortable and she felt like it was unnecessary because she knew when she needed to go to the bathroom and wanted to use the bed pan, not the brief. Resident #122 explained she knew how long it took because she would look at her watch. She added she had told the nurses about this, but nothing had changed.

An interview on 8/23/18 at 10:50 am with Nursing Assistant (NA) #13 revealed he routinely provided care for Resident #122. He stated the resident knew when she needed to go to the bathroom and used both the bed pan and briefs to relieve herself. NA #13 added the resident wore a brief every day and they would change her as needed.

An interview on 8/23/18 at 11:00 am with Unit Nurse Manager #2 revealed Resident #122 was physically incontinent but was able to tell the staff that she needed to go to the bathroom. She explained that when she said physically incontinent she meant the resident couldn ' t get up on her own and go to the bathroom or access the bed pan herself. She added if the resident requested the bed pan from the staff they should provide it for her. Unit Nurse Manager #2 added she wasn ' t aware that this was a concern for the resident.

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F 550	Continued From page 9 An interview on 8/23/18 at 12:05 pm with Nurse #10 revealed she believed Resident #122 was incontinent and used a brief to go to the bathroom. She stated she was not aware of the resident ' s desire or ability to use the bed pan. An interview with the Director of Nursing (DON) on 8/23/18 at 7:18 pm revealed it was her expectation that residents receive care that maintained their highest level of functioning and promoted their dignity.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to provide equipment to meet the needs for 2 of 3 residents reviewed for accommodation of needs. Resident #68 was not provided with the appropriate size shower bed resulting in the resident not receiving a shower for 5 weeks. Resident #122 was not provided with an appropriate size bed and wheelchair to accommodate her lower extremity lymphedema. Findings included: 1. Resident #68 was admitted on 6/14/2018 with diagnoses of paraplegia, hypertension, lack of coordination, muscle weakness, neurogenic	F 558	I. Facility failed to ensure accommodation of needs for Resident #68 who required a larger shower stretcher and Resident #122 who required a larger bed and wheelchair. a. Resident # 68 □ The facility ordered (2) new bariatric shower beds on 8/22/18 and these new bariatric shower beds are now in facility being utilized. Shower beds for the facility are operational and properly functioning. b. Resident #122 □ The facility provided a bariatric bed to this resident on 8/22/18. On 9/11/18, a bariatric wheelchair was provided to accommodate the needs of the resident.	9/20/18

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F 558	Continued From page 10 bladder, anemia and diabetes. Resident #68's Admission Minimum Data Set (MDS) dated June 21, 2018 revealed his cognition was intact. Resident #68 was totally dependent for bathing, required extensive assistance with bed mobility, toilet use, locomotion, dressing and person hygiene with two-person physical assist. A review of Resident #68 ' s care plan dated June 21, 2018 revealed there were interventions about activities of daily for Resident #68 for staff to provide assistant with all ADLS. Resident #68 needed two-person physical assistance with personal hygiene. During an interview with Resident #68 on 8/20/2018 at 1pm the resident stated he had not had a shower in 5 weeks (July 17, 2018) because the shower bed was too small for him. He added he felt very unsafe and couldn ' t move from one side to the other on the shower bed. Resident #68 indicated his shower days were Tuesday, Thursday and Saturday. Resident #68 indicated that he had reported this information to Nurses and Nursing Assistant on the hall. Review of the shower list revealed Resident #68 ' s scheduled shower days were Tuesdays, Thursdays and Saturdays. During a second interview with Resident #68 he revealed that he still had not had a shower. Resident #68 indicated he just wanted the facility to get a bigger shower bed, so he could have a shower. During an interview with Nursing Aide (NA) #2 on	F 558	II. A facility observation (round) was conducted on 09/20/18 by the Therapy Director, Director of Nursing (DON) and Assistant Director of Nursing (ADON) and/or Unit Managers. The observation included ensuring residents have the appropriate wheelchair and bed which accommodate their need such as weight, height, and other medical necessities. III. Beginning 9/27/18, the Therapy Director, DON or ADON will conduct facility observations weekly for twelve (12) weeks to ensure accommodation of needs for residents who may require a larger wheelchair or bed. Monthly for a minimum of three (3) months, the Director will report completed audit results to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months. IV. Director of Nursing will be responsible for overall compliance. Data results will be reviewed and analyzed at the centers monthly QAPI meeting with a subsequent POC as needed.	

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8/22/2018 at 9:30am revealed the shower bed broke over a month ago. NA #2 stated they needed a new shower bed for the bigger residents. NA #2 stated Resident #68 couldn ' t be rolled onto his side to wash his back because the shower bed was too small, and he would roll off.

During an interview with the Director of Nursing (DON) on August 22, 2018 at 7:45pm, she stated it was her expectation that residents have what was needed to meet their needs daily.

During an interview with the Administrator on August 22, 2018 at 7:45pm, he stated he expected the staff to inform him when special equipment was needed so the facility could accommodate all the needs of the residents.

2. Resident #122 was admitted to the facility on 7/23/18 and diagnoses included lymphedema, obesity, muscle weakness, lack of coordination and diabetes.

An admission minimum data set (MDS) dated 7/30/18 for Resident #122 revealed she required extensive, two person assist with bed mobility and toilet use. She required extensive, one person assist with personal hygiene and limited, one person assist with transfers. Her weight was 286 pounds and her cognition was intact.

Review of the medical record revealed no care plans had been developed for Resident #122.

An interview on 8/19/18 at 3:26 pm with Resident #122 revealed she felt uncomfortable and unsafe in her current bed. She stated the bed was too small for her and when the staff provided care for

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her or she tried to turn on her side she didn ' t have enough room and felt like she might fall off the bed. Resident #122 stated she had told the nursing staff she needed a larger bed but had not received one. She was unable to provide the names of the staff she had told. She stated she had a bruise behind her knee and she felt like that came from being moved around in the bed.

An observation of Resident #122 on 8/19/18 at 3:26 pm revealed she was lying in her bed on her back. The right side of her body from the waist down appeared to be hanging off the side of the mattress.

An observation of Resident #122 on 8/22/18 at 4:12 pm revealed her bed had been replaced with a larger, bariatric style bed.

An observation of Resident #122 on 8/23/18 at 11:50 am revealed she had a reddish, purple colored area that measured approximately 3 inches by 1 inch on the back of her right knee. Both legs were observed to very edematous. The resident was further observed to be transferred from the bed to a wheelchair with a mechanical lift and the assistance of 2 nursing assistants (NAs). When the resident was placed in the wheelchair she grimaced and stated she was not comfortable. The outer aspects of both of the resident ' s knees were observed to be rubbing on raised metal sections of the wheelchairs legs. Resident #122 stated she didn ' t know if she wanted to sit-up in the wheelchair because she was so uncomfortable, and she was worried how long they would make her sit-up before putting her back to bed. She added sometimes she had to sit-up for 4 hours and that was too long for her.

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An interview on 8/23/18 at 12:10 pm with Nurse #10 revealed she was the nurse for Resident #122. She stated she was not aware the resident was uncomfortable in the wheelchair they were using for her.

An interview on 8/23/18 at 12:15 pm with the Physical Therapy Assistant (PTA) revealed that Resident #122 would refuse to get out of bed to participate in therapy. He stated the Occupational Therapist (OT) had been working with the resident and he was not sure if the resident had been evaluated for a different wheelchair.

An observation on 8/23/18 at 1:55 pm of Resident #122 revealed she was in the therapy room and remained seated in her wheelchair.

An interview on 8/23/18 at 2:01 pm with the OT revealed he was placing some cushioning on the leg rests of Resident #122 ' s wheelchair. He stated the facility currently didn ' t have a wheelchair that would better accommodate the resident ' s lower extremity lymphedema. The OT added he hadn ' t assessed the resident ' s wheelchair prior to today.

An interview on 8/23/18 at 12:10 pm with the Physical Therapy Assistant (PTA) revealed if a resident was receiving both occupational and physical therapy the Physical Therapist (PT) would typically be the discipline that would evaluate a resident for the appropriate wheelchair. She added this had not been completed for Resident #122. The PTA stated the OT was going to apply some padding to the legs of the resident ' s wheelchair because the facility didn ' t currently have a chair that would be more comfortable for the resident with her

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F 558	Continued From page 14 lymphedema. She added she was going to discuss the need to get a more appropriate chair for Resident #122 with the facility Administrator. An interview with the Director of Nursing on 8/23/18 at 7:18 pm revealed it was her expectation that resident ' s physical needs are assessed and accommodated.	F 558		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the	F 561		9/20/18

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F 561	Continued From page 15 facility. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, record review and observation the facility failed to provide 2 of 3 residents (Resident #68 and Resident #80) the choice to have a shower for five weeks and 1 of 3 residents (Resident #132) for 2 weeks when reviewed for activities of daily living (ADL). Findings included: 1. Resident #80 was admitted to the facility on 9-11-15 with multiple diagnoses that included hemiplegia and hemiparesis affecting the left side, contracture of the left wrist, diabetes and cerebral infarction. The quarterly Minimum Data Set (MDS) dated 7-2-18 revealed Resident #80 was cognitively intact and was coded as needing extensive assistance with one person for bed mobility, dressing and personal hygiene, total assistance with 2 people for transfers, supervision with set up help for eating, total assistance with one person for toileting and total assistance for bathing. A review of Resident #80's care plan dated 7-12-18 revealed a goal that the resident would not display any signs or symptoms of infection. The interventions for that goal were as followed; ensure the resident has appropriate hygienic care with hand washing, bathing, hair, nail and perineal care. Resident #80 had another goal of being free from signs and symptoms of complications from her cerebral infarct. The interventions for that goal were as followed;	F 561	I. Facility failed to provide choices specifically showers as scheduled for Resident #68, Resident #80 and Resident #132. II. Education was provided from 09/15/18 - 09/19/18 to nursing staff by the Director of Nursing (DON) or Assistant Director of Nursing (ADON) related to ensuring care choices and activities of daily living (ADL) care is provided with emphasis on ensuring a shower is completed as scheduled and/or requested. Any nursing staff not completing education by 9/24/18 will be removed from the schedule until education is completed. Newly hired nursing staff will be educated by the Staff Development Coordinator during their orientation period on ensuring care choices and activities of daily living (ADL) care is provided. III. Beginning 9/25/18, shower audits will be conducted by the DON, ADON and/or Unit Manager (UM) twice weekly for twelve (12) weeks to ensure showers are completed as scheduled. Resident shower questionnaires will be provided with 10 residents weekly for twelve (12) weeks. Monthly for a minimum of three (3) months, the Director will report completed audit results to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the	

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F 561	Continued From page 16 monitor/document resident's abilities for activities of daily living and assist resident as needed. A review of the shower schedule for Resident #80 revealed she was to receive a shower on Monday, Wednesday and Fridays. During an interview with Resident #80 on 8-19-18 at 7:02pm she stated she had not had a shower in the month of July because the shower chair was broken. An interview with nursing assistant #1 (NA #1) occurred on 8-22-18 at 9:30am who stated the facility had a new shower chair that they received less than a month ago and that the old shower chair had been broken for over a month. She also stated they were unable to provide a shower to any of the residents who needed the shower chair during the time the shower chair was broken. During an interview with nursing assistant #2 (NA#2) on 8-22-18 at 9:40am she stated the NA's must fill out shower sheets every time a resident received a shower or bed bath because the sheet also had a place to assess the residents skin. NA #2 also stated she did not know why there were no shower sheets available for Resident #80 in the month of July. An interview with the unit Nurse Manager (#3) occurred on 8-22-18 at 9:50am. The nurse manager stated her employees are expected to fill out the shower sheets when a shower or bed bath was provided, and she did not know why resident #80 did not have any shower sheets available. During an interview with the Director of Nursing	F 561	audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months. IV. Director of Nursing will be responsible for overall compliance. Data results will be reviewed and analyzed at the centers monthly QAPI meeting with a subsequent POC as needed	

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and the Administrator on 8-23-18 at 7:30pm the Administrator stated he expected the residents to receive 2 showers a week at a minimum. The Director of Nursing stated she was unaware the shower sheets were not being utilized and that documentation was not being completed.

2. Resident # 132 was admitted to the facility on 6-28-18 with multiple diagnoses that included cerebral infarct, muscle weakness, dysphagia, flaccid hemiplegia and diabetes.

The significant change Minimum Data Set (MDS) dated 7-5-18 revealed Resident #132 was mildly cognitively impaired and was coded as needing limited assistance with one person for bed mobility, extensive assistance with 2 people for transfers, extensive assistance with one person for dressing, toileting and personal hygiene, supervision with one person for eating.

A review of Resident #132's care plan dated 7-23-18 revealed a goal that the resident will maintain current level of function. The interventions for that goal were as followed; staff will assist the resident to have a clean and neat appearance, the resident requires staff participation with bathing, personal hygiene and oral care.

Resident #132 was interviewed on 8-20-18 at 11:35am and stated he had not received a shower in 2 weeks because staff would not help him.

A review of the shower log revealed Resident #132 was to receive a shower on Monday, Wednesday and Fridays on second shift (3pm-11pm).

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A review of the shower logs from 5-1-18 to 8-22-18 revealed the last shower or bath received for Resident #132 was on 8-10-18

During an interview with nursing assistant #4(NA#4) on 8-22-18 at 5:15pm he stated he was the NA who cared for Resident #132 and usually provided the showers. He also stated he could not remember the last time he provided a shower or bath to Resident #132. NA #4 stated he did fill out the shower sheets when he provided a bath or shower to the resident but stated he did not know why there was no documentation from 8-10-18 to 8-22-18.

A review of the Nursing Assistant documentation for August in the electronic record revealed a nursing assistant provided a bath or shower to Resident #132 on 8-21-18.

An interview with Resident #132 occurred on 8-23-18 at 9:33am who stated he did not have a shower or a bath on 8-21-18 and that he had not had one for the last 2 weeks.

During an interview with nursing assistant #5 (NA #5) on 8-23-18 at 5:00pm she stated she had marked in the electronic record that she provided a bath to Resident #132 on 8-21-18 but that she had made a mistake and had not provided a shower or bath to Resident #132. She also stated she could not remember the last time the resident had a bath or shower.

An interview with the nurse manager #3 occurred on 8-23-18 at 5:03pm. She stated she was not familiar with the nursing assistant documentation, so she could not answer any questions if

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Resident #132 received any baths or showers in the last 2 weeks.

During an interview with the Director of Nursing and the Administrator on 8-23-18 at 7:30pm the Administrator stated he expected the residents to receive 2 showers a week at a minimum. The Director of Nursing stated she was unaware the shower sheets were not being utilized and that documentation was not being completed.

3. Resident #68 was admitted on 6/14/2018 with diagnoses paraplegia, essential hypertension, contracture, and left hand, other lack of coordination, muscle weakness, neurogenic bladder, anemia and type 2 diabetes.

Resident #68's Admission Minimum Data Set (MDS) dated June 21, 2018 revealed Resident #68 was cognitively intact. Resident #68 required extensive assistance with bed mobility, toilet use, locomotion, dressing and person hygiene with two person physical assist.

A review of Resident #68 care plan dated June 21, 2018 revealed there were interventions about activities of daily for Resident #68 for staff to provide assistant with all ADLS. Resident #68 needed two person physical assistance with personal hygiene.

During an interview with Resident #68 on 8/20/2018 at 1pm indicated he had not had a shower in 5 weeks (July 17, 2018) because shower bed was too small for him and felt very unsafe and want not able to move from one side to the other. Resident #68 indicated his shower days were Tuesday, Thursday and Saturday.

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F 561	Continued From page 20 Resident #68 indicated that he had report this information to Nurses and Nursing Assistant on the hall. Review of shower list revealed Resident #68 scheduled shower days were Tuesdays, Thursdays and Saturdays. During a second interview with Resident #68 he revealed that he still had not had a shower. Resident #68 indicated he just wanted the facility to get a bigger shower bed so he could have a shower. During an interview with Nursing Aide (NA) #2 on 8/22/2018 at 9:30am revealed the shower bed broke over a month ago. Stated they need a new shower bed. Stated it too small for the bigger residents. NA #2 stated Resident #68 cannot be rolled onto his side to wash his back because it too small of bed and he would roll off shower bed. During an interview with the Director of Nursing (DON) on August 22, 2018 at 7:45pm, she indicated her expectation is that all resident's choice of having shower should be honored. During an interview with Administrator on August 22, 2018 at 7:45pm, he indicated that his expectation that all residents choices be honored and if special equipment is needed, it needs to be order so we can meet that resident's needs.	F 561		
F 565 SS=D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family	F 565		9/20/18

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F 565	Continued From page 21 group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident interviews during the resident council meeting and review of the resident council meeting minutes the facility failed to allow the representatives of the resident council to voice their concerns and grievances during resident council meetings for (5) five consecutive months.	F 565	I. On 8/21/18, the resident council of the facility expressed concerns about not being able to voice grievances during the monthly resident council meeting. Based on these concerns, The Administrator and Director of Nursing will request permission	

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F 565	Continued From page 22 (March 2018, April 2018, May 2018, June 2018 and July 2018). Findings included: Record review of the Resident Council minutes dated March 21, 2018 revealed there were no concerns or grievances discussed. Record review of the Resident Council minutes dated April 11, 2018 revealed there were no concerns or grievances discussed. Record review of the Resident Council minutes dated May 9, 2018, revealed a special guest speaker (Social Services Director) who discussed the facility grievance policy, where to find the grievance forms, who can fill them out and the process of investigating a grievance to reach a resolution. A note indicated that no group concerns or grievances were discussed. Record review of the Resident Council minutes dated June 13, 2018 revealed there were no concerns or grievances discussed. Record review of the Resident Council minutes dated July 11, 2018 revealed there were no concerns or grievances discussed. During the Resident Council meeting held at 2PM on August 21, 2018 the resident council members stated they were told by the Activity Director not to discuss grievances or concerns during the Resident Council Meeting. The council members stated they could only talk about the things the activity staff wanted them to discuss. During the meeting, members of the resident council stated the former social worker would decide what was a	F 565	to attend the next scheduled resident council meeting to clarify. II. A resident council meeting will be held prior to 9/20/18. The Administrator, Director of Nursing, and Social Services will ensure residents are aware that they can voice their concerns/grievances in the resident council meeting. The Activities Director will document any concerns and/or grievances in the resident council meetings and will also write these concerns on a grievance form for resolution by the department heads. Upon admission, newly admitted residents will be provided information by the Social Services Director concerning the grievance process including emphasizing the ability to voice grievances during the facility resident council meeting. III. Monthly for three (3) months, the facility Director of Social Services will complete resident questionnaires on 10 residents to ensure they are aware that they can file grievances at any time including in the resident council meeting. The Director of Social Services will report completed audit results to the Quality Assurance and Performance Improvement Committee monthly for a minimum of (3) months. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	

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F 565	Continued From page 23 concern or grievance. The former social worker was not available to be interviewed during this survey. During an interview with the current Activity Director (AD) on August 21, 2018 at 3:45 PM she stated she had only been to one Resident Council meeting during the month of July 2018 and residents did not have any concerns or grievances. She indicated in her former job residents were able to voice resident concerns during the resident council meeting and staff would write-up the concerns/grievances and gave them to the department heads for resolutions. During a second interview with the AD on August 21, 2018 at 4:15 PM, she stated resident council members should not discuss concerns or grievances during Resident Council meetings because of the HIPAA (Health Insurance Portability and Accountability Act) law. The AD indicated that during resident council meetings residents should be able to discuss any issues and concerns they have. During an interview with the Director of Nursing (DON) on August 22, 2018 at 4 PM, she stated she expected concerns and grievances to be discussed at resident council meetings. During an interview with the Administrator on August 22, 2018 at 4pm, he indicated that the council members knew the location of his office and he had an open-door policy to discuss concerns and or grievances.	F 565	IV. Administrator will be responsible for overall compliance. Data results will be reviewed and analyzed at the centers monthly QAPI meeting with a subsequent POC as needed.	
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii)	F 583		9/20/18

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F 583	Continued From page 24 §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to provide privacy during a bath and obtaining a weight for Resident	F 583	I. On 8/21/18, Nurse Aide #10 was observed not providing privacy for Resident #16 while performing resident	

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F 583	Continued From page 25 #16 in 1 of 5 dependent residents reviewed. The findings included: Resident #16 was admitted to the facility on 10/07/2016 with cumulative diagnoses which included metabolic encephalopathy, cerebral infarction with left sided hemiparesis. Record review reviewed 5/8/18 quarterly Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status (BIMS) could not be completed due to impaired short and long-term memory problems. Resident #16 required the total assistance of one staff person for personal hygiene and bathing. 1.Observation on 08/21/18 at approximately 10 AM during personal care provided Nursing Assistant (NA) #10 was conducted. NA #10 removed the top sheet off Resident #16 exposing his nude body. Certified Medication Aide (CMA) #11 came in to the room and provided NA #10 a facility gown but NA #10 never covered the resident's nude body. NA #10 continued to provide care to the resident while being exposed. After the completion of care, NA #10 dressed the resident in a facility gown and brief. Resident #16 was cognitively impaired and could not be interviewed. Interview on 8/21/18 at 4:18 PM with Unit Manager #1 related she expected the resident to have privacy maintained during care and be treated with dignity and respect. Interview on 8/21/18 at 5:28 PM with the Director of Nursed who stated she expected privacy to be	F 583	care and obtaining a resident□s weight. Nurse Aide (NA) #10 was immediately provided one-to-one education by the facility Director of Nursing related to ensuring resident personal privacy is always maintained. Emphasis was placed on ensuring proper technique to promote privacy while performing any care tasks with residents. II. The Director of Nursing or Assistant Director of Nursing provided education to nursing from 09/15/18 - 09/19/18 on ensuring privacy while performing care tasks with residents. Any nursing staff who have not completed education by 9/24/18 will be removed from the schedule until education is completed. During orientation period, newly hired nursing staff will be educated by the Staff Development Coordinator on ensuring privacy while performing care. III. Beginning 9/25/18, three times weekly for six (8) weeks then weekly for four (4) weeks, care rounds will be conducted by the Director of Nursing, Assistant Director of Nursing, Unit Manager and/or designee to ensure privacy is maintained with residents while providing care tasks. Monthly for a minimum of three (3) months, the Director will report completed audit results to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further	

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F 583	Continued From page 26 provided. 2. Observation on 08/21/18 10:45 AM revealed Nursing Assistant (NA) #10 transferred Resident #16 out of bed to a chair to obtain the resident's weight. Resident #16 worn a facility gown opened in the back and a brief. The scale was located directly across from the nurses' station and elevator. NA #10 transferred Resident #16 onto the scale with his bare back and brief exposed. There were two (2) residents in view at the nurses' station. Resident #16 was cognitively impaired and could not be interviewed. Interview on 8/21/18 at 4:18 PM with Unit Manager #1 related she expected the resident to have privacy maintained and be treated with dignity and respect. Interview on 8/21/18 at 5:28 PM with the Director of Nursed who stated she expected privacy to be provided.	F 583	auditing beyond the three months. IV. Director of Nursing will be responsible for overall compliance. Data results will be reviewed and analyzed at the centers monthly QAPI meeting with a subsequent POC as needed.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.	F 584		9/20/18

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F 584	Continued From page 27 (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews and staff interviews the facility failed to (1) maintain walls and ceilings in resident's rooms for 13 of 16 rooms (rooms 200, 206, 218, 229, 306, 315, 403, 414, 420, 427, 429, 431 and 530)., (2) maintain a clean environment in residents rooms for 4 of 16 rooms (rooms 229, 414, 420 and 427), (3) provide nightstands without missing drawers in residents rooms for 2 of 16 rooms (rooms 427	F 584	I. As a result of the age of the facility, it is pertinent that the facility maintain a safe, clean and homelike environment. On 8/24/18, facility rooms 200, 206, 218, 229, 306, 315, 403, 414, 420, 427, 429, 431, and 530 have been assessed by maintenance personnel for wall and ceiling concerns. Each of the areas identified have been resolved.	

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F 584	Continued From page 28 and 530) and the facility failed to (4) provide sufficient and clean linens that were not stained, thread bare or torn on 2 of 4 resident care units (units 300 and 500). Findings included: 1a. An observation of room 200 was conducted on 8-19-18 at 2:27pm. The molding along the floor in the bathroom was noted to be loose from the wall. A subsequent observation of room 200 was conducted on 8-22-18 at 3:00pm at which time the molding along the floor in the bathroom was noted to be loose from the wall. An interview with the maintenance director occurred on 8-22-18 at 3:01pm who stated he had not had time to make all the necessary repairs needed since his return in April 2018. During an interview with the Administrator and Director of Nursing on 8-23-18 at 7:30pm the Administrator stated the facility was trying to finalize a contract for remodeling but until that was completed he expected repairs to be made. b. Room 206 was observed on 8-22-18 at 3:05pm and was noted to have paint peeling off the wall exposing the plaster beside the resident's bed. An interview with the maintenance director occurred on 8-22-18 at 3:06pm who stated he had not had time to make all the necessary repairs needed since his return in April 2018. He also stated he did not have a plan in place to repair any of the peeling paint in any of the rooms but realized he needed to start making weekly	F 584	Facility rooms 429, 414, 420, and 427 was assessed and cleaned on 08/24/18 by the Housekeeping Department. On 8/2/18, the maintenance department assessed facility rooms 427 and 530 and well-conditioned nightstands with drawers were placed in these rooms for resident storage and functionality. Units 300 and 500 had their linen par levels reviewed by the Housekeeping Supervisor on 08/24/18 and inadequate linen(s) were discarded and replaced as needed. II. On 8/24/18, an observation round was conducted by the Maintenance Supervisor to determine if additional rooms needed repairs due to wall/ceiling issues or broken nightstands to ensure a homelike environment. On 8/24/18, the Housekeeping Supervisor conducted a facility observation to identify any additional rooms which may need additional cleaning due to unclean and or unsanitary environment. III. Beginning 09/24/18, Maintenance Team will audit rooms weekly x 6 weeks then monthly for three (3) months to evaluate for safe, clean and homelike environment and will repair concerns as needed. Beginning 09/24/18, Housekeeping will audit rooms weekly x 6 weeks then	

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F 584	Continued From page 29 rounds in every room. During an interview with the Administrator and Director of Nursing on 8-23-18 at 7:30pm the Administrator stated the facility was trying to finalize a contract for remodeling but until that was completed he expected repairs to be made. c. An observation of room 218 occurred on 8-19-18 at 6:40pm. There was a hole in the wall behind the resident's bed. A subsequent observation of room 218 occurred on 8-22-18 at 3:08pm. A hole was noted to be behind the resident's bed measuring approximately 2inx2in. An interview with the maintenance director occurred on 8-22-18 at 3:09pm who stated he had not had time to make all the necessary repairs needed since his return in April 2018. During an interview with the Administrator and Director of Nursing on 8-23-18 at 7:30pm the Administrator stated the facility was trying to finalize a contract for remodeling but until that was completed he expected repairs to be made. d. An observation of resident room 229 occurred on 8-19-18 at 2:30pm. The molding around the bathroom floor was noted to be loose from the wall and chipped. A second observation of room 229 was made on 8-22-18 at 3:12pm and the molding around the floor in the resident's bathroom was noted to be loose from the wall and a corner of the molding was broken off.	F 584	monthly for three (3) months to assure resident rooms are clean and sanitary to maintain homelike environment Beginning 09/24/18, Housekeeping Manager will review par levels at least bi-weekly x 6 months and will report findings to the Administrator to determine if new linens need to be ordered. IV. Administrator will be responsible for overall compliance. Monthly for a minimum of three (3) months, audits will be reviewed and analyzed for further auditing as needed to ensure ongoing compliance at the centers monthly QAPI meeting with a subsequent POC as needed.	

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An interview with the maintenance director occurred on 8-22-18 at 3:13pm who stated he had not had time to make all the necessary repairs needed since his return in April 2018. He also stated he had received several feet of new molding so he could start his repairs.

During an interview with the Administrator and Director of Nursing on 8-23-18 at 7:30pm the Administrator stated the facility was trying to finalize a contract for remodeling but until that was completed he expected repairs to be made.

e. An observation of room 306 occurred on 8-19-18 at 2:56pm and was noted to have molding around the resident's floor as you enter the room on the right that was loose from the wall with jagged edges.

Room 306 was observed again on 8-22-18 at 3:15pm and was found to have loose molding around the floor as you enter the resident's room to the right of the door and the molding was noted to have jagged edges.

An interview with the maintenance director occurred on 8-22-18 at 3:16pm who stated he had not had time to make all the necessary repairs needed since his return in April 2018.

During an interview with the Administrator and Director of Nursing on 8-23-18 at 7:30pm the Administrator stated the facility was trying to finalize a contract for remodeling but until that was completed he expected repairs to be made.

f. An observation of room 315 was conducted on 8-19-18 at 4:17pm and the resident's room was noted to have a hole in the bathroom door.

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During a second observation of room 315 on 8-22-18 at 3:20pm a hole was noted approximately 3 inches in diameter in the resident's bathroom door.

An interview with the maintenance director occurred on 8-22-18 at 3:21pm who stated he had not had time to make all the necessary repairs needed since his return in April 2018.

During an interview with the Administrator and Director of Nursing on 8-23-18 at 7:30pm the Administrator stated the facility was trying to finalize a contract for remodeling but until that was completed he expected repairs to be made.

g. An observation of room 403 was conducted on 8-20-18 at 2:21pm and was noted to have plaster showing on the walls in the resident's room.

A subsequent observation of room 403 was made on 8-22-18 at 3:25pm. The resident's walls were noted to have plaster showing.

An interview with the maintenance director occurred on 8-22-18 at 3:26pm who stated he had not had time to make all the necessary repairs needed since his return in April 2018.

During an interview with the Administrator and Director of Nursing on 8-23-18 at 7:30pm the Administrator stated the facility was trying to finalize a contract for remodeling but until that was completed he expected repairs to be made.

h. An observation of room 414 was made on 8-19-18 at 4:43pm. During the observation, the resident's room was noted to have paint chipping

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off the walls showing plaster and there was a hole and water damage on the ceiling above the window. The resident's bathroom wall on the left had a hole, molding loose from the wall and the paint and plaster were chipped away exposing metal in the wall.

A second observation of room 414 was made on 8-22-18 at 3:28pm revealing the resident's walls had paint chipping exposing the plaster underneath and an approximate 2inch x 2inch hole in the ceiling along with water damage above the window. The bathroom in room 414 was observed to have an approximate 2inch x 1inch hole in the left wall by the molding, the molding was loose from the wall and an approximate 3inch x 4inch area of the wall where the paint and plaster had been chipped away exposing a metal strip that was in the wall.

An interview with the maintenance director occurred on 8-22-18 at 3:30pm who stated he had not had time to make all the necessary repairs needed since his return in April 2018. He also stated he did not realize metal was exposed and that he would have the wall repaired immediately.

During an interview with the Administrator and Director of Nursing on 8-23-18 at 7:30pm the Administrator stated the facility was trying to finalize a contract for remodeling but until that was completed he expected repairs to be made.

I. An observation of room 420 occurred on 8-20-18 at 9:16am. The resident's room revealed a hole in the wall across from the bed and another hole in the wall across from the closet and the molding around the floor by the bathroom

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was loose from the wall.

A subsequent observation of room 420 was made on 8-22-18 at 3:33pm revealing an approximate 2inch x 2inch hole in the wall across from the resident's bed, an approximate 2inch by 2inch hole in the wall across from the resident's closet and the molding around the floor by the bathroom was loose from the wall.

An interview with the maintenance director occurred on 8-22-18 at 3:35pm who stated he had not had time to make all the necessary repairs needed since his return in April 2018.

During an interview with the Administrator and Director of Nursing on 8-23-18 at 7:30pm the Administrator stated the facility was trying to finalize a contract for remodeling but until that was completed he expected repairs to be made.

j. An observation of room 427 occurred on 8-19-18 at 5:48pm. The observation revealed paint peeling off the walls below the window, the ceiling above the window, the bathroom wall had paint and plaster chipped off exposing a metal strip in the wall and paint peeling off the bathroom door. The observation also revealed a hole in the ceiling above the window and molding loose from the bottom of the closet and the wall in the bathroom.

Another observation of room 427 was made on 8-22-18 at 3:37pm and revealed paint chipping off the wall above the air unit, ceiling above the window, bathroom door and paint and plaster chipped off on the wall in the bathroom exposing a metal strip in the wall. There was also a hole in the ceiling approximately 4inches x 3inches

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above the window and an indentation approximately 2inches x 3inches in the wall across from the bathroom.

An interview with the maintenance director occurred on 8-22-18 at 3:40pm who stated he had not had time to make all the necessary repairs needed since his return in April 2018. He also stated he would have the residents moved out of room 427 as soon as possible so repairs could be completed.

During an interview with the Administrator and Director of Nursing on 8-23-18 at 7:30pm the Administrator stated the facility was trying to finalize a contract for remodeling but until that was completed he expected repairs to be made.

k. An observation of room 429 occurred on 8-19-18 at 5:15pm. During the observation it was noted that paint was peeling off the ceiling above the window.

A second observation was completed on 8-22-18 at 3:42pm which revealed paint peeling off the ceiling above the window.

An interview with the maintenance director occurred on 8-22-18 at 3:45pm who stated he had not had time to make all the necessary repairs needed since his return in April 2018.

During an interview with the Administrator and Director of Nursing on 8-23-18 at 7:30pm the Administrator stated the facility was trying to finalize a contract for remodeling but until that was completed he expected repairs to be made.

l. Room 431 was observed on 8-19-18 at 4:01pm

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revealing brown marks on the ceiling on each side of the bed, a hole in the ceiling above the window and the wall chipped of its paint and plaster exposing metal.

During another observation of room 431 on 8-22-18 at 3:47pm the residents room was noted to have large brown stains on the ceiling on either side of the resident's bed, a hole approximately 2inches x 4 inches in the ceiling above the window and the edge of the wall by the bathroom had the paint and plaster chipped away exposing a metal strip in the wall.

An interview with the maintenance director occurred on 8-22-18 at 3:50pm who stated he had not had time to make all the necessary repairs needed since his return in April 2018. He also stated he had received a work order for the residents ceiling regarding the brown stains yesterday (8-21-18) and planned on beginning the work today.

During an interview with the Administrator and Director of Nursing on 8-23-18 at 7:30pm the Administrator stated the facility was trying to finalize a contract for remodeling but until that was completed he expected repairs to be made.

m. An observation of room 530 occurred on 8-20-18 at 11:41am. During the observation, the resident's room was noted to have a hole in the wall behind the door, the toilet paper holder was broken and there was a hole in the wall to the right of the bed.

A second observation was made of room 530 on 8-22-18 at 3:53pm. The resident's room was noted to have an approximate 3inch x 3inch hole

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in the wall behind the door entering the room, an approximate 2inch x 3inch hole in the wall to the right of the resident's bed and in the resident's bathroom the toilet paper holder cover was broken with pieces of plastic missing.

An interview with the maintenance director occurred on 8-22-18 at 3:55pm who stated he had not had time to make all the necessary repairs needed since his return in April 2018. He also stated he would have the toilet paper holder replaced immediately.

During an interview with the Administrator and Director of Nursing on 8-23-18 at 7:30pm the Administrator stated the facility was trying to finalize a contract for remodeling but until that was completed he expected repairs to be made.

2a. An observation of resident room 229 occurred on 8-19-18 at 2:30pm. The resident's room was noted to have black and brown spots on the floor by the bed.

A second observation of room 229 was made on 8-22-18 at 3:12pm and the floor in the resident's room was noted to have brown spots between the bed and the wall.

An interview with the housekeeping manager occurred on 8-22-18 at 3:13pm who stated there was not any housekeeping staff after 2:00pm on the weekends and after 3:00pm on the weekdays so the floors would not have been cleaned on 8-22-18 at 3:12pm till the next morning.

During an interview with the Administrator and Director of Nursing on 8-23-18 at 7:30pm the Administrator stated the facility was trying to

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finalize a contract for remodeling but until that was completed he expected repairs to be made.

b. An observation of room 414 was made on 8-19-18 at 4:43pm. During the observation, the resident's room was noted to have lady bugs, moths and dust in the air/heating unit vents.

A second observation of room 414 was made on 8-22-18 at 3:28pm and revealed the resident's air/heating unit vents contained dead lady bugs, moths and dust.

An interview with the maintenance director and the housekeeping manager occurred on 8-22-18 at 3:30pm. The maintenance director stated they have been removing the vents and cleaning them as they notice a need. The housekeeping manager stated his staff would report to maintenance when a vent was needed to be cleaned and did not know why that did not occur for room 414.

During an interview with the Administrator and Director of Nursing on 8-23-18 at 7:30pm the Administrator stated the facility was trying to finalize a contract for remodeling but until that was completed he expected repairs to be made.

c. An observation of room 420 occurred on 8-20-18 at 9:16am. The resident's room revealed dirt and black spots on the air/heating unit vent.

A subsequent observation of room 420 was made on 8-22-18 at 3:33pm revealing dirt and black spots on the air/heating unit vent.

An interview with the maintenance director and the housekeeping manager occurred on 8-22-18

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at 3:35pm. The maintenance director stated they have been removing the vents and cleaning them as they notice a need. The housekeeping manager stated his staff would report to maintenance when a vent was needed to be cleaned and did not know why that did not occur for room 420.

During an interview with the Administrator and Director of Nursing on 8-23-18 at 7:30pm the Administrator stated the facility was trying to finalize a contract for remodeling but until that was completed he expected repairs to be made.

d. An observation of room 427 occurred on 8-19-18 at 5:48pm. The observation revealed black spots on the air/heating unit vent and the bath tub was noted to have a yellow/orange coloring around the faucet and drainage area and black streaks in the tub.

Another observation of room 427 was made on 8-22-18 at 3:37pm and revealed black spots on the vent in the air/heating unit and the bath tub was noted to have a yellow/orange coloring around the faucet and drainage area and black streaks in the tub.

An interview with the maintenance director and the housekeeping manager occurred on 8-22-18 at 3:40pm. The maintenance director stated they have been removing the vents and cleaning them as they noticed a need. The housekeeping manager stated his staff would report to maintenance when a vent was needed to be cleaned and did not know why that did not occur for room 427. He further stated the chemicals he needed to use to clean the tub correctly he was not allowed to be used while the residents were in

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the room but that he could try an oxidizing agent.

During an interview with the Administrator and Director of Nursing on 8-23-18 at 7:30pm the Administrator stated the facility was trying to finalize a contract for remodeling but until that was completed he expected repairs to be made.

3a. An observation of room 427 occurred on 8-19-18 at 5:48pm. The observation revealed the resident was missing the bottom drawer of his nightstand.

During an interview with Resident #28 on 8-19-18 at 5:48pm the resident stated "those drawers don't work right. I wish they would fix them."

Another observation of room 427 was made on 8-22-18 at 3:37pm and revealed the resident's night stand did not have a bottom drawer.

An interview with the maintenance director occurred on 8-22-18 at 3:40pm who stated he had not had time to make all the necessary repairs needed since his return in April 2018. He also stated he would have the night stand replaced.

During an interview with the Administrator and Director of Nursing on 8-23-18 at 7:30pm the Administrator stated the facility was trying to finalize a contract for remodeling but until that was completed he expected repairs to be made.

b. An observation of room 530 occurred on 8-20-18 at 11:41am. During the observation, the resident's room was noted to have the top drawer of his night stand missing.

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A second observation was made of room 530 on 8-22-18 at 3:53pm. The resident's room was noted to have the top drawer of his night stand missing.

An interview with the maintenance director occurred on 8-22-18 at 3:55pm who stated he had not had time to make all the necessary repairs needed since his return in April 2018. He also stated he would have the night stand replaced.

During an interview with the Administrator and Director of Nursing on 8-23-18 at 7:30pm the Administrator stated the facility was trying to finalize a contract for remodeling but until that was completed he expected repairs to be made.

3. Resident # 25 was admitted to the facility on 1/24/18 with heart failure, diabetes mellitus, left below the knee amputation, and depression.
A review of Resident #25's most recent MDS (Minimum Data Set) dated 5/4/18 was coded as a quarterly assessment. The MDS revealed Resident #25 was with slight cognitive

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impairment. Active diagnoses included heart failure, diabetes mellitus, left below the knee amputation, and generalized weakness.
An interview was conducted with Resident #25 on 8/20/18 at 11:34am. He reported frequently the facility does not have clean linens or wash cloths/towels. An observation was made during the interview that the resident did not have sheets on the bed. Resident #25 reported that he hoped the staff would find sheets before he was put back to bed.
An interview was conducted on 8/22/18 at 5:00pm with NA #6. NA #6 reported that second shift frequently ran out of wash cloths, towels, and linens. She reported if she doesn't have wash cloths or towels to clean residents, she has used pillow cases and sheets.
4. Resident #2 was admitted to the facility on 7/10/17 with dementia, mood disorder, and bipolar disease.
A review of Resident #2's most recent MDS dated 6/4/18 and coded as a quarterly assessment revealed the resident is cognitively impaired.

An observation was made on 8/22/18 at 2:50pm of Resident #2's bed linens. The resident's sheet was thin and transparent with 2 holes noted in the sheet near the middle of the sheet. One hole measured 2 centimeters by 1 centimeter and the other hole measured 3 centimeters by 2 centimeters.

5.Observation on 08/21/18 at approximately 10 AM during bed linen change revealed Nursing Assistant (NA) #10) placed a torn fitted sheet on the bed.

Observation on 8/21/18 at 10:40 AM in the 5th

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floor clean linen closet revealed:
1 torn and yellow colored stained fitted sheet.
4 of 7 fitted sheets were torn at the seam around the edge of the fitted sheet.

Interviews and observations in the laundry area on 8/21/18 at 10:48 AM with the contracted housekeeping and laundry services were conducted with the Laundry/Housekeeping Manager (LHM), District Manager, and Laundry Aide #7 was held. The laundry cart for 5th floor was prepared for distribution to the unit had 5 of 25 fitted sheets that were thread bared, with holes and torn corners, of the fitted sheets, and 1 torn gown with 3 holes and stained. LHM indicated laundry staff and himself tag out (remove) all torn and threadbare linens prior to being delivered to the unit.

Observation on 8/21/18 at 10:48 AM of the clean linen room located in the laundry room revealed (2) bundles of industrial cotton wash cloths were stored directly on the floor. The floor tiles were heavily stained with a black colored substance with an accumulation of dirt and dust. There were 3 black colored plastic fasteners on the floor with dust on them. On the shelves were bundles of wash cloths and linens. Under the shelving was trash and an accumulation of dust and dirt. By 11 AM the Administrator observed the condition of the clean linen room.

Interview on 8/21/18 at 3 PM with NA #10 revealed the only available linen he had to use was the torn fitted sheet to change Resident #16's bed.

Interview on 8/22/18 at 11:25 AM with NA #12 revealed sometimes staff have to wait for spreads

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F 584	Continued From page 43 and 50% of the time the linens are torn and do not have enough linens to make the beds without using the torn ones. On 8/22/18 at 6:10 PM an interview with the Administrator revealed he expected torn and stained linens to be pulled out of circulation and new linens used. An interview was conducted on 8/23/18 at 8:00pm with the Administrator. He reported it was his expectation that all staff had enough wash cloths and towels to perform their job. He also reported it was his expectation that all linen be in good repair without holes or stains or worn thin.	F 584		
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or	F 623		9/20/18

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discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual

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F 623	Continued From page 45 and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide written notification to the resident representative and the ombudsman when a resident was transferred to the hospital.	F 623	I. Upon review, facility did not provide resident nor resident□s responsible party with a written notification upon transfer to the hospital as the result of facility not	

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F 623	Continued From page 46 This was evident for 1 of 1 resident that was reviewed for hospitalizations (Resident #353). Findings Included: Resident #353 was admitted to the facility on 2/9/18 and her diagnoses included paraplegia, neurogenic bladder, urinary tract infections, seizures, malnutrition, chronic pain syndrome and anxiety. A quarterly minimum data set dated 7/16/18 for Resident #353 revealed her cognition was intact. Review of the medical record for Resident #353 revealed she was hospitalized and re-admitted to the facility on the following dates: hospitalized 4/14/18 and re-admitted 4/23/18, hospitalized 5/13/18 and re-admitted 5/19/18, hospitalized 6/9/18 and re-admitted 6/20/18, hospitalized 6/30/18 and re-admitted 7/9/18, hospitalized 8/3/18 and re-admitted 8/8/18. An interview on 8/23/18 at 6:13 pm with Social Worker (SW) #1 revealed that the SW ' s didn ' t complete written notification to the resident ' s representative or the facility ombudsman when a resident was discharged to the hospital. She stated maybe the business office did the notification. SW #1 added she believed the nursing staff called a resident ' s family if they went out to the hospital. An interview on 8/23/18 at 6:16 pm with the Business Office Manager (BOM) revealed the business office did not provide any written notification to the resident ' s representative or the facility ombudsman when a resident went out to the hospital. She stated the facility SW ' s were	F 623	having a process in place to provide written notification to the residents and or their representatives. Social Services to compile post 30-day resident discharge summary/log and will send to Ombudsmen as required by regulation. II. Education was provided from 09/15/18 - 09/19/18 to Nursing Staff and Social Services Department by the Director of Nursing and Assistant Director of Nursing on ensuring the letter of discharge is provided to the resident and resident representative upon transfer to the hospital. Licensed Nurses will record the reasons for the transfer or discharge in the resident□s medical record. Any nursing staff or social services staff who has not completed education by 9/24/18, will be removed from the schedule until education is completed. As requested by Ombudsman, Social Services Director will maintain Transfer/Discharge Binder and submit notice of transfer log to Ombudsman monthly. III. Beginning 9/24/18, an audit will be conducted weekly for twelve (12) weeks by the Social Service Director to ensure upon discharge to hospital, a letter of discharge is provided to the resident and resident representative and notice of transfer log is sent to Ombudsman. V. Social Service Director will report findings and resolution monthly for a minimum of three (3) months to the QAPI	

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F 623	Continued From page 47 usually the staff members that worked with the ombudsman. A phone message was left for the facility ombudsman on 8/23/18 at 6:26 pm. No return call was received. An interview on 8/23/18 at 6:56 pm with the Director of Nursing (DON) revealed the facility currently did not have a process in place to provide written notification to the resident ' s representatives and the facility ombudsman when residents were hospitalized.	F 623	Committee. Data results will be reviewed and analyzed for the need for further monitoring beyond the three months with subsequent POC as needed. Social Service Director and Administrator will be responsible for overall compliance.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights 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	F 656		9/20/18

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WINSTON SALEM NURSING & REHABILITATION CENTER	1900 W 1ST STREET WINSTON-SALEM, NC 27104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 48 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a care plan for 6 of 6 care areas that were identified on the care area summary (CAA) of the minimum data set (MDS) by the 21st day of admission. This was evident for 1 of 3 residents reviewed for accommodation of needs (Resident #122). Findings Included: Resident #122 was admitted to the facility on 7/23/18 and diagnoses included lymphedema, obesity, diabetes, hypertension, lack of coordination and muscle weakness. An admission MDS dated 7/30/18 for Resident #122 revealed the CAA summary (Section V) identified care plans would be developed for communication, activities of daily living (ADLs)	F 656	I. The facility failed to develop a care plan for 6 of 6 care areas that were identified on the care area assessment (CAA) of the minimum data set (MDS) by the 21st day of admission. Resident #122 identified had their care plan corrected and updated during the Annual Survey Process. The facility to provide the CAA on the 21st day of admission. II. A comprehensive care plan audit will be performed by the MDS Coordinator(s) to ensure development of care plan by the 21st day of admission. This audit will be completed by 9-20-18. III. Re-education of the development of comprehensive care plans was provided by facility MDS Consultant 9-13-18 to	

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F 656	Continued From page 49 urinary incontinence, falls, nutritional status and pressure ulcers. Review of the medical record revealed a nutrition care plan dated 8/22/18. There were no other care plans available for Resident #122. An interview on 8/23/18 at 4:12 pm with MDS Nurse #1 revealed the care plans for Resident #122 had not been completed until 8/22/18 and they were not within the 21-day requirement for completion. An interview on 8/23/18 at 7:18 pm with the Director of Nursing (DON) revealed it was her expectation that comprehensive care plans were completed by the 21st day of admission.	F 656	MDS Coordinator(s) and Interdisciplinary(IDT)Team. Staff to utilize care areas identified on the care area summary (CAA) of the MDS. Section 5 identified care plans that would be developed. Ongoing new MDS and IDT staff will receive education upon hire by the MDS Consultant, and or a RAC staff member. IV. New Admission Comprehensive Assessments will be audited beginning 9-10-18 and on going for completeness, timeliness per the RAI guidelines. Audits of the new admission will be conducted weekly x 4 weekly, monthly x 3 months. Progress will be reported to the QAPI committee by the MDS Coordinator. Administrator will be responsible for overall compliance. Data results will be reviewed and analyzed at the centers monthly QAPI meeting with a subsequent POC as needed	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to follow physician orders on 1 out of 1 resident (Resident #153) on intermittent tube feedings. Findings include:	F 658	I. Resident #153 enteral feed was noted to not be infusing as per physician order on 8/19/18. Unit Manager #4 was provided one-to-one education concerning accuracy of tube feeding administration	9/20/18

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F 658	Continued From page 50 Resident #153 was admitted to the facility on 1/24/14 with diagnoses that included Dementia, Dysphagia, Aphasia, and Seizure Disorder. A review of Resident #153's most recent MDS (Minimum Data Set) dated 7/16/18 was coded as a quarterly assessment. The resident was coded as cognitively impaired. Active diagnoses included dementia, seizure disorder, and dysphagia. Resident #153 was coded as total dependence in all areas of activities of daily living. The resident was coded under Nutrition as receiving 51% or more nutrients by tube feeding. A review of Resident #153's care plan revealed the resident required tube feeding related to dysphagia. Resident #153 was care planned for tube feeding dated 7/6/18. A review of Resident #153's medical record revealed a physician's order dated 5/1/18 that read Glucerna 1.5 at 80ml/hr for 18 hours (2pm to 8am) off at 8am. A review of Resident #153's medical record revealed a dietician quarterly assessment dated 6/30/18 which read that the resident required Glucerna 1.5 at 80ml/hr(milliliters/hour) over 18 hours with flushes of 250 ml of water every 4 hours to achieve recommended nutrition and fluids. An observation was made on 8/19/18 at 2:54pm of Resident #153 with tube feeding container full and marked "feeding on 2pm and off 8am." Tube feeding apparatus was connected to the resident but the tube feeding pump was not turned on. An observation was made at 8:00pm on 8/19/18 of Resident #153 with tube feeding container continued to be full, tubing hooked up to the resident's feeding tube, and tube feeding pump was not turned on. An interview was conducted with Unit Nurse Manager #4 on 8/21/18 at 10:55am. He reported	F 658	per physician order. This education was provided by the Director of Nursing on 8/21/18. II. Education was conducted by the Director of Nursing and Assistant Director of Nursing to Licensed Nurses from 09/15/18 - 09/19/18. This education included ensuring Licensed Nurses follow physician orders as written with emphasis on accurately administrating tube feeding orders as written by physician. Any Licensed Nurse who has not completed education by 9/24/18 will be removed from the schedule until education is completed. During orientation, newly hired Licensed Nurses will be educated by the Staff Development Coordinator on ensuring physician orders are followed as written by the physician. III. Beginning 09/25/18, daily for two (2) weeks, three times weekly for six (6) weeks then weekly for four (4) weeks, audits will be conducted on (5) residents requiring continuous tube feeding by the Director of Nursing, Assistant Director of Nursing and/or Unit Managers. These audits will be conducted to validate Licensed Nurses are following physician orders for residents who receive tube feedings. Physician order will be reviewed and compared to resident□s continuous tube feeding being administered to ensure accuracy per physician order. Monthly for a minimum of three (3) months, the Director will report completed audit results to the Quality Assurance and Performance Improvement Committee.	

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F 658	Continued From page 51 Resident #153 was to receive her tube feedings from 2pm every afternoon until 8am the next morning. He reported he didn't know why the tube feeding did not run 8/19/18 afternoon/evening. He reported he was the one to hang and disconnect the resident's tube feedings when he was working. He reported he worked 8/19/18. An interview was conducted with the DON (Director of Nursing) on 8/23/18 at 8:00pm. The DON reported it was her expectation that the staff follow physician orders for residents who receive tube feedings to ensure the resident receives the amount of nutrients required.	F 658	The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months. IV. Director of Nursing will be responsible for overall compliance. Data results will be reviewed and analyzed at the centers monthly QAPI meeting with a subsequent POC as needed	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, interviews with staff and record reviews the facility failed to provide a complete and thorough bath for Resident #16 in 1 of 5 residents dependent on staff for care. (Resident #16) Findings included: Resident #16 was admitted to the facility on 10/07/2016 with cumulative diagnoses which included metabolic encephalopathy, cerebral infarction with left sided hemiparesis. Record review reviewed 5/8/18 quarterly Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status (BIMS) could not	F 677	1. Nurse Aide #10 failed to complete a thorough bath on Resident #16 while care observations were being conducted during annual survey. Nurse Aide #10 was provided one-to-one education on 8/22/18 by the facility Director of Nursing concerning the proper procedure for performing a complete bath on a resident. Nurse Aide #10 provided a successful return demonstration. 2. Education was provided to nursing staff from 09/15/18 - 09/19/18 by the Director of Nursing and Assistant Director of Nursing on the proper procedure for completing a bath including mouth care.	9/20/18

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F 677	Continued From page 52 be completed due to impaired short and long-term memory problems. Resident #16 required the total assistance of one staff person for personal hygiene and bathing. Review of the bedside cardex used by the Nursing Assistant (NA) to provide care revealed in part: " Under Personal Hygiene/Oral Care Section the resident required staff participation with personal hygiene and oral care. " Under Bladder/Bowel Section staff were to wash, rinse and dry the perineum (genital area) Observation on 08/21/18 at approximately 10 AM during personal care provided by NA #10 was conducted and revealed the Resident #16 had experienced a urine and stool incontinent episode. NA #10 performed the following: " NA #10 explained to the resident what he was doing. " Obtained a basin of plain water, towels, wash cloths, linens and bath/body cleanser. " NA #10 removed the top sheet off the resident exposing his entire nude body. " Used a wash cloth and cleansed the resident's face. " Another wash cloth was used with the bath cleanser and washed the Resident #16's chest, both arms, and legs at once with the same washcloth. Then folded the same washcloth and washed the right and left side of his groin. " NA #10 did not cleanse the genitals, feet or hands. " No mouth care was provided. Interview on 8/21/18 at 3 PM with NA #10 who stated he usually provided care just as he had done. During the interview NA #10 stated he	F 677	Any nursing staff who has not completed this education by 09/24/18 will be removed from the schedule until education is completed. Newly hired nursing staff will have education by the Staff Development Coordinator on proper procedure for completing a bath including mouth care during their orientation period. 3. Beginning 09/25/18, care observations to ensure proper procedure will be conducted by the Unit Managers on Nurse Aides performing baths. These observations will be conducted with three (3) Nurse Aides three times weekly for twelve weeks on various shifts. Monthly for a minimum of three (3) months, the Director will report completed audit results to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months. 4. Director of Nursing will be responsible for overall compliance. Data results will be reviewed and analyzed at the centers monthly QAPI meeting with a subsequent POC as needed.	

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F 677	Continued From page 53 used the cardex to let him know what care the resident required. NA #10 stated he washed the top of the resident's feet and hands but just did not wash in-between the fingers and toes but thought he washed the resident's genitals. Interview on 8/21/18 at 4:18 PM with Unit Manager #1 stated she expected NA to provide mouth care, cleanse the genitals and between resident's fingers and toes. Interview on 8/21/18 at 5:28 PM with the Director of Nurses who stated she expected the NA to wash the entire resident's body and provide pericare (perineum care).	F 677		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to provide nail care to Resident #16's feet. This was evident in 1 of 5 dependent residenst reviewed for activities of daily living. Findings included:	F 687	I. Facility failed to ensure proper foot care on Resident #16. Resident #16 was observed to have long toe nails extending beyond 1/4 of nail bed. Facility coordinated podiatry services for Resident #16. Toe nails trimmed by facility podiatrist	9/20/18

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F 687	Continued From page 54 Resident #16 was admitted to the facility on 10/07/2016 with cumulative diagnoses which included metabolic encephalopathy, cerebral infarction with left sided hemiparesis. Record review reviewed 5/8/18 quarterly Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status (BIMS) could not be completed due to impaired short and long-term memory problems. Resident #16 required the total assistance of one staff person for personal hygiene and bathing. Observation of Resident #16 on 08/19/18 at 2 PM revealed the resident's toe nails were long extending approximately 1/4 inch above the nail bed. Observation on 8/19/18 at 6:30 PM revealed Resident #16's toe nails remained long. Observation on 8/20/18 at 12:14 pm revealed Resident #16's toe nails remained long. Observation on 8/20/18 at 2 pm revealed Resident #16's toe nails remained long. Observation on 08/21/18 at approximately 10 AM Resident #16's toe nails remained long. Interview on 8/21/18 at approximately 11 AM and again on 8/22/18 at 3 PM with the Director of Social Work (DOSW) revealed the podiatrist and the previous administrator would fax back and forth resident names who required podiatry services. Once the list was finalized she was provided the names and date of when the podiatrist would come to the facility. Interview on 8/21/18 at 4:18 PM with Unit Manager #1 who stated Resident #16's toe nails were thick and could not be cut by staff.	F 687	on 8/22/18. II. Unit Managers conducted a facility audit to ensure proper foot care on 8/22/18. A podiatry list was established for residents who needed immediate podiatry services. Podiatry services was conducted by the facility Podiatrist on 8/22/18. Education was provided from 09/15/18 - 09/19/18 by the facility Director of Nursing or Assistant Director of Nursing to nursing staff on ensuring proper foot care. Any resident requiring Podiatry services will be referred to the facility Podiatrist as necessary. Any nursing staff who has not completed this education by 09/24/18 will be removed from the schedule until education is completed. Newly hired nursing staff will be educated during their orientation period by the Staff Development Coordinator on ensuring proper foot care. III. Monthly beginning 10/05/18, the Unit Managers will complete an audit to ensure proper foot care. Any resident noted to need podiatry services which requires a Podiatrist will be referred as needed. Monthly for a minimum of three (3) months, the Director of Nursing will report completed audit results to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further	

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F 687	Continued From page 55 Review of the podiatrist list provided on 8/22/18 by the (DOSW) with a faxed date and time of 8/21/18 at 9:55 PM revealed only the list of resident names from the 200 hall and 500 hall. Resident #16's name was not listed to be seen by the podiatrist. DOSW indicated she spoke with the podiatrist and Resident #16 was placed on the list on to be seen. Interview on 08/22/18 at 11:25 AM with Nursing Assistant (NA) #12 who stated she was aware of the long toe nails and the nurse (does not know the name) who conducted the initial assessment of the resident was to place the resident's name on the podiatrist list. NA #12 thought the resident was on the podiatry list. Interview on 8/23/18 at 7:13 PM with the Director of Nurses (DON) who stated she expected the managers to review and modify the podiatrist list based on the resident's needs during morning meetings then provide the modified list to the social worker. The DON also stated she expected the managers to identify resident care needs and provide the services.	F 687	auditing beyond the three months. IV. Director of Nursing will be responsible for overall compliance. Data results will be reviewed and analyzed at the centers monthly QAPI meeting with a subsequent POC as needed	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of	F 688		9/20/18

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F 688	Continued From page 56 motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to apply bilateral hand splints to 1 out of 2 residents (Resident #158) reviewed with hand contractures. Findings include: Resident #158 was admitted to the facility on 4/8/11 with diagnoses that included persistent vegetative state and contractures to the left and right hands. A review of Resident #158's most recent MDS (Minimum Data Set) dated 7/18/18 was coded as a quarterly assessment. Resident #158 was coded as cognitively impaired. Active diagnoses included vegetative state and contractures to left and right hands. The resident was coded as total dependent with all activities of daily living. A review of Resident #158's care plan dated 7/8/18 revealed the resident was care planned for alteration in musculoskeletal status related to contractures of multiple joints. A review of Resident #158's medical record revealed an OT (Occupational Therapist) note dated 4/23/18 that ordered the resident to wear bilateral protective splints on hands to prevent further hand contractures. A review of Resident #158's medical record revealed a restorative note dated 8/10/18 which read that the resident is tolerating passive range	F 688	I. Resident #158 had orders for bilateral splints. Facility failed to ensure splints were in place as ordered. Resident #158 was referred to therapy services on 9/7/18 to screen for different type of hand splint. Orders have been updated to reflect current splint status as of 9/11/18. II. Education was provided from 09/15/18 - 09/19/18 to nursing staff by the Director of Nursing or Assistant Director of Nursing on ensuring splints are applied as ordered. Any nursing staff who has not completed this education by 09/24/18 will be removed from the schedule until education is completed. Newly hired nursing staff will be educated during their orientation period by the Staff Development Coordinator on ensuring splints are applied as ordered. III. Beginning 09/24/18, splint audits will be conducted by the Restorative Nurse, Unit Manager or Supervisor five (5) times a week for four (4) weeks then three (3) times a week for eight (8) weeks to ensure splints are applied as ordered. Monthly for a minimum of three (3)	

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F 688	Continued From page 57 of motion with palm guard splinting bilateral hands. The note reported Resident #158 would remain An observation was made on 8/19/18 at 4:54pm of Resident #158 with no hand splints in place. Hands were severely contracted with fingers pressed into the palms of his hands. Observations were made of Resident #158 on 8/20/18 at 12:00pm, 3:11pm and 4:33pm with no hand splints in place each time. An observation was made of Resident #158 on 8/21/18 at 12:00pm with no hand splints in place. An interview was conducted on 8/21/18 at 4:53pm with the restorative nurse. She reported the restorative aide removed the bilateral hand splints from Resident #158 three times a day and performed passive range of motion to each hand then reapplied the splints after the treatment nurse applied Nystatin powder to the palms of Resident #158's hands. The restorative nurse reported the resident was to wear the palm guard hand splints 24 hours a day, 7 days a week. An interview was conducted on 8/21/18 at 5:50pm with Unit Nurse Manager #4. He reported Resident #158 was to wear bilateral hand palm splints 24 hours a day, 7 days a week. He reported the restorative aide performed passive range of motion three times a day but reapplied the splints after therapy. An interview was conducted on 8/22/18 at 12:12pm with Restorative Aide #1. She reported she performed passive range of motion every morning and it was done every shift on Resident #158. She reported she had left off the splints for the past 2 weeks because the resident had skin breakdown in his palms. An interview was conducted with the DON (Director of Nursing) on 8/23/18 at 8:00pm. She reported it was her expectation that the staff	F 688	months, the Director of Nursing will report completed audit results to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months. IV. Director of Nursing will be responsible for overall compliance. Data results will be reviewed and analyzed at the centers monthly QAPI meeting with a subsequent POC as needed.	

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F 688	Continued From page 58 followed orders for applying splints to contractures to prevent further decline in joints.	F 688		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility's medication rate was greater than 5% as evidenced by 3 medication errors out of 27 opportunities for errors (Resident #159 and Resident #180). The medication error rate was 11.11%. Findings include: 1. Resident #159 was admitted to the facility on 6/29/18 with diagnoses that included Depression, Schizophrenia, and Chronic Obstructive Pulmonary Disease. A review of Resident #159's medical record revealed a physician's order for Invega 3mg by mouth daily for schizophrenia and Advair 250 by mouth daily for Chronic Obstructive Pulmonary Disease. An observation of medication administration was made on 8/21/18 at 8:20am with Nurse #6. Nurse #6 was observed to not give Resident #159 his Advair and Invega medications. It was observed that Nurse #6 noted in MAR (Medication Administration Record) the medications of Advair	F 759	I. Resident #159 and Resident #180 did not receive their medication due to the medication(s) being unavailable from pharmacy per Nurse #6. a. Resident #159 Advair and Invega was delivered to the facility on 8/21/18. b. Resident # 180 Protonix was delivered to the facility on 8/21/18. II. Between 09/04/18 - 09/11/18 a medication administration record (MAR) to medication cart audit was conducted by the Unit Managers, Supervisors, Director of Nursing and Assistant Director of Nursing on current residents to ensure medication availability for current medication orders. Any missing medications was ordered and confirmed receipt from the pharmacy. Education was provided from 09/15/18 - 09/19/18 by the Director of Nursing or Assistant Director of Nursing to all Licensed Nurses and Medication Aides on medication pharmacy ordering process. This will include education on current facility pharmacy back-up services, reorder guidelines with	9/20/18

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WINSTON SALEM NURSING & REHABILITATION CENTER	1900 W 1ST STREET WINSTON-SALEM, NC 27104

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F 759	Continued From page 59	F 759		

and Invega were not given to Resident #159 due to not having the medication.

An interview was conducted on 8/21/18 at 8:20am with Nurse #6. She reported Resident #159 did not receive his medications because the medications had not arrived from the pharmacy yet. She reported the medications were reordered and faxed to the pharmacy but had not arrived.

Another interview was conducted on 8/21/18 at 3:27pm with Nurse #6. She reported the medications for Resident #159 had not been delivered from the pharmacy

2. Resident #180 was admitted to the facility on 7/25/18 with diagnoses that included Gastroesophageal Reflux Disease, Hypertension, and Peripheral Vascular Disease.

A review of Resident #180's medical record revealed a physician's order written for Protonix 40mg by mouth daily for Gastroesophageal Reflux Disease.

An observation of medication administration was made on 8/21/18 at 8:25am with Nurse #6. It was observed that Nurse #6 did not Resident #180 his Protonix. Nurse #6 noted on Resident #180's MAR that the medication was not available.

An interview was conducted on 8/21/18 at 8:30am with Nurse #6. She reported Resident #180 did not receive his medications because the medications had not arrived from the pharmacy yet. She reported the medication was reordered and faxed to the pharmacy but had not arrived.

Another interview was conducted on 8/21/18 at

cut-off times, delivery days/times and the facility Stat-Safe (electronic emergency medication dispensing machine) utilization. Any Licensed Nurse or Medication Aide who has not completed education by 09/24/18, will be removed from the schedule until education is completed.
Newly hired Licensed Nurses and Medication Aides will be educated by the facility Staff Development Coordinator on pharmacy medication ordering process.

III. Beginning 09/25/18, MAR to medication cart audits will be conducted by the Unit Managers and Assistant Director of Nursing twice weekly for twelve (12) weeks to ensure resident medication are available from the pharmacy. Any medications unavailable will be ordered and confirmed receipt from the pharmacy by the Unit Managers. Monthly for a minimum of three (3) months, the Director of Nursing will report completed audit results to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.

IV. Director of Nursing will be responsible for overall compliance. Data results will be reviewed and analyzed at the centers monthly QAPI meeting with a subsequent POC as needed.

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F 759	Continued From page 60 3:27pm with Nurse #6. She reported the medication for Resident #180 had not been delivered from the pharmacy. An interview was conducted with the DON (Director of Nursing) on 8/23/18 at 8:00pm. She reported it was her expectation that each resident received his/her medications as ordered and on time.	F 759		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview and staff interviews the facility failed to administer 1 of 1 residents (Resident #99) thyroid medication for seven consecutive days, sedative medication for 8 consecutive days and the resident's anticoagulation medication for 4 consecutive days when reviewed for significant medication errors. Findings included: Resident #99 was admitted to the facility on 9-8-17 with multiple diagnoses that included chronic respiratory failure, atrial fibrillation, left ventricular failure, hyperthyroidism and schizoaffective disorder. The annual Minimum Data Set (MDS) dated 7-10-18 revealed that Resident #99 was cognitively intact and coded as needing supervision with set up help for bed mobility, independent with set up help for transfers and	F 760	I. Resident #99 did not receive her Eliquis, Synthroid and Temazepam as ordered by the physician due to medication not being available from pharmacy. Resident #99 Eliquis, Synthroid and Temazepam was verified to be available and on medication cart on 8/23/18. II. Between 09/04/18 - 09/11/18, a medication administration record (MAR) to medication cart audit was conducted by the Unit Managers, Supervisors, Director of Nursing and Assistant Director of Nursing on all current facility residents to ensure medication availability for current medication orders. Any missing medications will be ordered and confirmed receipt from the pharmacy. Education was provided from 09/15/18 - 09/19/18 by the Director of Nursing and Assistant Director	9/20/18

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F 760	Continued From page 61 eating, supervision with one person for dressing and personal hygiene and extensive with one person for toileting. A review of Resident #99's care plan dated 7-30-18 revealed a goal that the resident would not have any drug related complications. The interventions for that goal were as followed; administer medication as ordered, monitor, record and report to the physician any side effects or adverse reactions. The resident also had a goal that she would not have any complications related to her hyperthyroidism. The interventions for that goal were as followed; give thyroid replacement therapy as ordered, monitor, document and report to the physician any signs or symptoms of hyperthyroidism. Resident #99's care plan also had a goal that she would not have any discomfort or adverse reaction related to anticoagulation use. The interventions for that goal were as followed; monitor, document and report to the physician any signs or symptoms of anticoagulant complications and review medication list for adverse interactions. During an interview with Resident #99 on 8-20-18 at 10:05am she stated she had not received her Eliquis medication (an anticoagulation medication) as ordered because the pharmacy was not delivering them. An interview with nurse #6 occurred on 8-21-18 at 8:35am who stated if a resident was running out of their medication, the nurse must send a refill request by fax to the pharmacy by 3:00pm and that the medication was usually delivered by the next morning. A review of the physician orders from July 2018	F 760	of Nursing to all Licensed Nurses and Medication Aides on medication pharmacy ordering process. This will include education on current facility pharmacy back-up services, reorder guidelines with cut-off times, delivery days/times and the facility Stat-Safe (electronic emergency medication dispensing machine) utilization. Any Licensed Nurse or Medication Aide who has not completed education by 09/24/18, will be removed from the schedule until education is completed. Newly hired Licensed Nurses and Medication Aides will be educated by the facility Staff Development Coordinator on pharmacy medication ordering process. III. Beginning 09/25/18, MAR to medication cart audits will be conducted by the Unit Managers and Assistant Director of Nursing twice weekly for twelve (12) weeks to ensure resident medication are available from the pharmacy. Any medications missing will be ordered and confirmed receipt from the pharmacy by the Unit Managers. Monthly for a minimum of three (3) months, the Director will report completed audit results to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months. IV. Director of Nursing will be	

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F 760	Continued From page 62 and August 2018 revealed: Synthroid 100mcg by mouth daily. Synthroid was a drug used to control hyperthyroidism Temazepam 15mg by mouth at bed time. Temazepam was used to aid in sleeping Eliquis 5mg by mouth twice a day. Eliquis was used for anticoagulation therapy. There were no physician orders to withhold these medications. A review of Resident #99's medication record for July 2018 and August 2018 revealed the following; Synthroid 100mcg by mouth daily was not given from 7-7-18 to 7-14-18, Temazepam 15mg by mouth at bed time was not given from 7-16-18 to 7-24-18, Eliquis 5mg by mouth twice a day was not given from 8-16-18 to 8-22-18. The reason listed was that the medications were not available. A review of the nursing progress notes from July 2018 and August 2018 revealed there was no documentation regarding Resident #99 not receiving her prescribed medication. An interview with Resident #99 occurred on 8-22-18 at 12:15pm. The resident stated she had a headache over the last 2 days and felt it was from not receiving her Eliquis and she had been fearful that she would have a stroke. She also stated last month (July 2018) she could not sleep for a week around the middle of the month because she did not have her Temazepam, and that she had did not eat well last month (July 2018) and felt that was because she did not have her Synthroid. During an interview with nurse #7 on 8-23-18 at 9:20am she stated she faxed her medication refill	F 760	responsible for overall compliance. Data results will be reviewed and analyzed at the centers monthly QAPI meeting with a subsequent POC as needed.	

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F 760	Continued From page 63	F 760		

requests to the pharmacy 2 times and if the medication still had not arrived she would then call the pharmacy. The nurse #7 discussed the pharmacy not delivering medications over the weekend or on Mondays and she was concerned because "the residents are missing their medications that could cause them to have a seizure, stroke or start acting out." Nurse #7 stated she had discussed the issue with the unit nurse manager, but nothing had been done. She also stated the facility had an emergency stock of medication but that it did not contain brand name medication and that there was not a backup pharmacy available.

An interview with the contracted pharmacist where the medications are acquired from occurred on 8-23-18 at 12:15pm. The pharmacist stated he had received a request for Resident #99's Synthroid to be filled on 7-12-18 and it was sent to the facility on 7-18-18. He stated the delay in delivering the Synthroid was because it was the weekend. The pharmacist stated he received a request to fill Resident #99's Temazepam on 7-21-18 and that it was sent to the facility on 7-23-18. He stated he could not locate the request for the Eliquis in August at this time but that refills maybe faxed or called into the pharmacy and the medication was then packaged and shipped either by UPS or FedEx.

A review of faxed medication refill requests and confirmation sheets revealed that Resident #99's Eliquis was faxed and received by the pharmacy on 8-13-18.

Continued interview with the pharmacist on 8-23-18 at 4:40pm he stated they had missed the request on 8-13-18 but that the facility could have

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F 760	Continued From page 64 made a follow-up call and requested the Eliquis to be filled and the pharmacy would have contacted the local back up pharmacy and had it delivered in 1-2 hours. Further interview revealed the contracted pharmacy had several local pharmacies' the facility can use should the medication be needed immediately. During an interview with the Administrator and Director of nursing on 8-23-18 at 7:30pm the Director of Nursing stated that she expected her staff to follow up on pharmacy requests and to not have any medications missed.	F 760		
F 761 SS=D	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 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	F 761		9/20/18

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F 761	Continued From page 65 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 secure a prescription bottle of Nystatin powder for 1 out of 1 resident (Resident #158). Findings include: Resident #158 was admitted to the facility on 4/8/11 with diagnoses that included persistent vegetative state and bilateral contractures of hands. A review of Resident #158's medical record revealed a physician's order dated 7/10/18 that read to apply Nystatin powder to resident's palms prior to applying splints each day. An observation was made on 8/22/18 at 12:17pm of Resident #158's Nystatin powder bottle lying on the resident's bed near his left knee. An interview was conducted with Unit Nurse Manager #4 on 8/22/18 at 12:20pm. The Unit Nurse Manager #4 reported all prescription medications including powders are to be kept locked in the medication cart or the medication storage room. He reported no medications should be left in a resident's room and he removed the Nystatin powder. An interview was conducted with the DON (Director of Nursing) on 8/23/18 at 8:00pm. She reported that it was her expectation that all medications are kept locked in the medication cart or medication storage room when not in use.	F 761	I. On 8/22/18, a medication (Nystatin powder) was inadvertently left on the bed of Resident #158 after completion of a resident treatment. The medication was removed from Resident #158 bed and secured in the medication cart on 8/22/18. II. Director of Nursing or Assistant Director of Nursing provided education from 09/15/18 - 09/19/18 to Licensed Nurses and Medication Aides concerning ensuring medications are stored properly, secured and not left at bedside. Any Licensed Nurse or Medication Aide who has not completed education by 09/24/18, will be removed from the schedule until education is completed. Newly hired Licensed Nurses and Medication Aides will be educated during their orientation period per Staff Development Coordinator concerning ensuring medications are stored properly, secured and not left at bedside. III. Beginning 09/25/18, observation rounds including room inspections will be conducted by the Unit Managers or RN Supervisors three (3) times weekly for twelve (12) weeks to ensure medications are stored properly and not at bedside. Monthly for a minimum of three (3) months, the Director will report completed audit results to the Quality Assurance and Performance Improvement Committee.	

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F 761	Continued From page 66	F 761	The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months. IV. Director of Nursing will be responsible for overall compliance. Data results will be reviewed and analyzed at the centers monthly QAPI meeting with a subsequent POC as needed	
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, resident interview, staff interviews and observations the facility failed to honor the food preferences for 1 of 3 residents (Resident #180) reviewed for food palatability. Findings included: Resident #180 was admitted to the facility on 7-25-18 with multiple diagnoses that included coronary artery disease, peripheral vascular disease, diabetes and cerebral infarct.	F 806	I. Facility did not honor food preference of Resident #180 as a result of not obiding by the resident□s food card nor updating the food card with additional dislikes i.e., beans. On 08/31/18, Resident #180 card was updated/revised to include resident□s likes and dislikes. II. By 9/20/18, Dietary Manager and/or Dietician will audit resident meal cards to assure most updated information reflects	9/20/18

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F 806	Continued From page 67 The admission Minimum Data Set (MDS) dated 8-1-18 revealed the resident was cognitively intact and coded as needing supervision with one person assisting for dressing and eating. A review of Resident #180's physician orders for August 2018 revealed an order for a cardiac diet. An observation of the lunch tray occurred on 8-19-18 at 1:30pm. The menu for lunch included pinto beans however Resident #180 was noted to have baked beans on his tray. During an interview with Resident #180 on 8-19-18 at 1:30pm he stated he had informed the dietary staff that he could not eat beans "but they keep putting them on my plate." A review of Resident #180's meal card did not contain beans as a dislike. An observation of the dinner tray occurred on 8-19-18 at 7:00pm. Resident #180 was noted to have turkey, rice and vegetable medley that contained corn and carrots. During an interview with Resident #180 on 8-19-18 at 7:00pm he stated he could not eat most of his food because they were items he did not like "I have told them I don't like rice, corn or carrots and you see what is on my plate." A review of Resident #180's meal card revealed a list of dislikes that included rice, carrots and corn. An interview with the Dietary Manager occurred on 8-22-18 at 8:42am. The Dietary manager stated he was aware that the residents on the	F 806	residents likes and dislikes. By 9/20/18, Dietary and Nursing staff will be educated to assure that resident meal cards are reviewed for accuracy with meal services by Dietary Manager and Director of Nursing. Newly hired staff members will also be educated to this process upon hire by Dietary Manager, Director of Nursing and or Staff Development Coordinator. III. On 9/17/18, Dietary Manager and/or Dietician began randomly auditing (10) residents weekly x 6 months then monthly x 3 months to assure accuracy to likes and dislikes. VI. Dietary Manager, Dietician, and Administrator will be responsible for overall compliance. Data results will be reviewed and analyzed at the centers monthly QAPI meeting with a subsequent POC as needed.	

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F 806	Continued From page 68 fourth floor were not happy with the meal service and were receiving meals with foods that were marked as dislikes. He stated he was aware the staff working the service line were not reading the meal cards to see what the residents likes, and dislikes were. The Dietary Manager stated he was working with the staff on the service line to be more aware of what was on the meal cards for each resident. During an interview with nursing assistant (NA #10) on 8-23-18 at 9:30am she stated she "just passed out the tray" and did not look to see what the resident received. NA #10 stated she believed that was dietary's job but if a resident requested something else she would get that for them. During an interview with the Administrator and Director of Nursing on 8-23-18 at 7:30pm the Administrator stated they were making some changes in dietary but until that was completed he expected services to be rendered as listed.	F 806		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident	F 809		9/20/18

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F 809	Continued From page 69 group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interviews the facility failed to offer or deliver bedtime snacks to 4 of 4 residents (Resident #3, Resident #68, Resident #141, and Resident #157). Finding included: During observations on August 22, 2018 from 7:30pm until 9:30pm, no one was observed passing out snacks and / or offering residents snacks on the 300 hall, 400 hall and 500 hall. During an interview with Resident #3 on August 22, 2018 at 8:15 pm, the resident stated no one had offered her a snack. Resident #3 also indicated "you can see the snacks on top of the dinner cart but we never get them." During an interview with Resident #157 on August 22, 2018 at 8:15pm, she stated that no one had offered her a snack tonight. During an interview with Resident #141 on August 22, 2018 at 8:22pm, he indicated that no one had offered him a snack, and this was what happened all the time. During an interview with Resident #68 on August 22, 2018 at 8:30pm, he stated he was a diabetic	F 809	I. On 8/22/18, the facility failed to offer or deliver bedtime snacks to Resident #3, Resident #68, Resident #141 and Resident #157. II. Director of Nursing or Assistant Director of Nursing provided education from 09/15/18 - 09/19/18 to nursing staff on ensuring bedtime snacks are offered to each resident daily. Any nursing staff who has not completed education by 09/24/18 will be removed from the schedule until education is completed. Newly hired nursing staff will be provided education concerning bedtime snacks being offered to each resident daily by Staff Development Coordinator. III. Beginning 09/25/18, bedtime snack questionnaires will be conducted with residents by the RN Supervisor or Unit Managers to ensure bedtime snacks are being offered to residents. These questionnaires will be conducted with (15) residents daily for two (2) weeks, three times weekly for six (6) weeks then weekly for four (4) weeks. Monthly for a minimum of three (3) months, the Director of Nursing will report completed audit results to the Quality Assurance and	

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F 809	Continued From page 70 and his sugar was fine tonight, but he wasn't offered a snack tonight. A continuous observation was done on 400 hall from 8:30pm until 9:30pm and no snacks were observed to be offered to the residents. A second observation was done of Resident #3 and Resident #157's room on August 22, 2018 at 9:04pm and no snacks were observed in the room. Resident #3 indicated no one had came by to deliver anything. A second observation of Resident #141's room on August 22, 2018 at 9:08pm revealed no snacks were observed in the room. During an interview with Nursing Assistant #42 on August 22, 2018 at 9:10pm she revealed that snacks were passed out between 7:30pm and 8:30pm. NA #42 stated she would get to it and wanted to know who wanted a snack now. During an interview with Nursing Assistant #43 on August 22, 2018 at 9:20pm she revealed this was her second night on the hall, but snacks should be passed out between 8pm and 9pm. During an interview with the Dietary Manager on August 23, 2018 at 8:35am he revealed that snacks were prepared daily for all residents in the facility and the NAs on the halls were responsible for passing out the snacks between 8pm and 9pm and as needed for the residents. During an interview with the Director of Nursing on August 23, 2018 at 4pm she indicated it was her expectation that snacks were offered and delivered to each resident every night.	F 809	Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months. IV. Director of Nursing will be responsible for overall compliance. Data results will be reviewed and analyzed at the centers monthly QAPI meeting with a subsequent POC as needed	

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F 809	Continued From page 71 During an interview with the Administrator on August 23, 2018 at 4pm he indicated it was his expectation that nursing offer all residents a snack at night.	F 809		
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 by: Based on observations and staff interviews the facility failed to ensure foods were sealed, labeled and dated when stored, failed to discard an expired food product and failed to keep nourishment room storage equipment clean. This was evident in 1 of 1 kitchen observation and 2 of 2 nourishment room observations. (200 hall and 500 hall)	F 812	I. Facility did not label, seal, or date open food items as determined per facility policy. Items noted upon observation were either discarded, labeled and stored properly per facility policy in facility kitchen and storage areas. On 08/24/18, 200 and 500 Hall Nourishment Room was cleaned per	9/20/18

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F 812	Continued From page 72 Findings Included: 1. An observation of the kitchen with the Dietary Manager (DM) on 8/19/18 at 2:00 pm revealed: a. A five-pound bag of milk powder was open and exposed to the air in the dry storage room. b. Open cases of vegetable blend, sliced bread, hamburger rolls, kielbasa sausage, Salisbury steak patties, beef steak fritters and breaded crab cakes were open and exposed to the air in the walk-in freezer. c. A container of hot dog chili with an expiration date of May 2018 was in the walk-in refrigerator. An interview with the DM on 8/19/18 at 2:30 pm revealed opened food products should be sealed, labeled and dated. He added foods should be discarded within the expiration date. 2. An observation of the 200-hall nourishment room on 8/23/18 at 11:20 am revealed the following: a. A sticky, red substance was present on the lower shelf and lower drawers of the refrigerator. An unidentified food product was wrapped in aluminum foil with no label or date. b. A sticky, orange substance was present on the inside door shelf of the freezer. There were 3 foam cups that all contained a frozen substance, straw and were covered with paper towels. There was no label or date present. An interview with the DM on 8/23/18 at 4:39 pm revealed housekeeping was responsible for cleaning the nourishment room refrigerators. He stated dietary was responsible to label and date food items sent from the kitchen and nursing was responsible for labeling food items residents wanted stored in the refrigerator.	F 812	Housekeeping. On 08/23/18, improperly stored items were discarded by Dietary staff. II. On 08/24/18, Housekeeping Manager assessed and cleaned nourishment rooms to include cabinets and refrigerators throughout facility. On 8/24/18, Dietary services discarded items improperly labeled, sealed, dated and or expired. On 08/24/18, Housekeepers were educated by the Housekeeping Supervisor on ensuring nourishment room cabinets and refrigerators are cleaned appropriately. On 9/16/18, Dietary Dept. were educated by the Dietary Manager on ensuring proper food procurement with proper storage and labeling of food items in kitchen and nourishment rooms. Between 09/15/18 - 09/19/18, Nursing staff were educated by the Director of Nursing and Assistant Director of Nursing on ensuring proper food procurement with proper storage and labeling of food items in nourishment rooms. This education will also be provided in new employee orientation by Staff Development Coordinator for employees hired within these departments. III. Beginning 09/24/18, Dietary Manager and/or assistant will audit nourishment rooms within facility weekly for twelve (12)	

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F 812	Continued From page 73 An interview on 8/23/18 at 8:12 pm with the Administrator revealed it was his expectation that expired foods were discarded, foods were sealed and stored with labels and food storage areas were clean. 3.Observation of the 5th floor nourishment room was conducted on 8/23/18 at 10:28 AM revealed: a. In the freezer Section of the refrigerator: On the freezer floor there were splattered dried yellow and red colored sticky substance. There were also black colored particles. The back of the freezer wall had black, blue, red and green colored splattered stains. There were black colored dried splattered substances on the outside of the freezer door. A frozen meal, a bar of chocolate candy and a bag of steamable broccoli and cauliflower mixture was stored in the freezer without a resident name and date. The brackets of the door were missing. b.In the refrigerator section Two (2) brackets inside of the door were missing. There were two (2) white colored shelves. One (1) had areas of rust colored stains. When touched the rust colored areas were sticky. The second shelf had a red colored substance that was sticky. There was a piece of plastic stored inside the refrigerator that fit one of the broken bin handle. There were 12 prepackaged thickened liquid cartons stored in the refrigerator bin in liquid. The glass shelving had splatters of a red colored dried sticky substance. The outside surface of the door had an	F 812	weeks. Beginning 09/20/18, Housekeeping Manager will audit to ensure nourishment rooms are clean and sanitary daily (5x) per week for twelve (12) weeks. Beginning 09/20/18, Dietary services will check refrigerators and cabinets at least 4x weekly for twelve (12) weeks to ensure adherence to properly stored and labeled items. VII. Dietary, Housekeeping Manager, and Administrator will be responsible for overall compliance. Data results will be reviewed and analyzed at the centers monthly QAPI meeting with a subsequent POC as needed.	

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F 812	Continued From page 74	F 812		

accumulation of a black colored substance.

c.The microwave had a brown colored dried substance inside.

d.The wall had peeling paint.

e.In the cabinets were packets of ketchup and mayo, an uncovered plastic ice scoop, plastic paper plates and a 10- inch serrated knife covered in brown paper towels.

f. The floor corners of the nourishment room had a heavy accumulation of a black colored substance. Beside the ice machine and the wall was a heavy buildup of a black colored substance in the corners extending onto the floor with an accumulation of dust and trash. The floor tiles were crack with a pieces of floor tile missing.

Interview and observation on 08/23/18 at 10:55 AM with Housekeeper (HK) #14 stated she just mopped the floor this morning (referring to 8/23/18) and cleaned the refrigerator. HK #14 observed the accumulation of black and brown colored substances in the corners and extending to the floor, the build-up of a black colored substance along the base boards and corners and the status of the refrigerator. HK #14 indicated that the floor cleaning was the floor tech responsibility and had not informed anyone about the status of the nourishment room.

On 08/23/18 at 11:03 AM Laundry/Housekeeping Manager (LHM), stated the HK #14 was new to the unit and should have cleaned the floor. Continued interview revealed housekeeping and dietary staff were responsible for cleaning the

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F 812	Continued From page 75 refrigerators and the floors. But was not sure who was responsible for cleaning the microwave. An interview on 8/23/18 at 8:12 pm with the Administrator revealed it was his expectation that food storage areas (nourishment room) were clean.	F 812		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review of the facility's Quality Assessment and Assurance Committee (QAA) the facility failed to maintain implemented procedures and monitor interventions that the committee put into place following the 8-24-17 annual recertification survey. This was for 4 recited deficiencies in the areas of food procurement, store/prepare/serve and sanitation (F812), safe/clean/comfortable/homelike environment (F584), free from significant medication errors (F760) and free of medication error rate of 5% or more (F759). These deficiencies were cited on the annual recertification survey on 8-24-17. The continued failure of the facility during 2 Federal surveys of record showed a pattern of the facility's inability to sustain an effective QAA program. Findings included:	F 867	F867 QAPI/QAA Improvement Activities I. On 09/07/18, an Ad-hoc QAPI Meeting was held with department managers to review areas of non-compliant practice per facility policy and procedures identified in F tag 867 per CMS-2567 Form and low adherence to facility□s performance improvement measures as outlined by facility QAPI process. II. On 09/07/18, Department Managers was re-educated by facility Nursing Consultant to the facility□s QAPI process by: " Defining the QAPI process " Incorporating process that is on-going and comprehensive	9/20/18

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F 867	Continued From page 76 This tag was cross referenced to: 1.F371 - Based on observations and staff interviews the facility failed to store foods in sealed, labeled and dated containers, failed to maintain clean kitchen equipment and failed to allow dishware to air dry. During the annual recertification survey on 8-23-18, the facility was cited for F812; Based on observations and staff interviews the facility failed to ensure foods were sealed, labeled and dated when stored, failed to discard an expired food product and failed to keep nourishment room storage equipment clean. This was evident in 1 of 1 kitchen observation and 2 of 2 nourishment room observations. (200 hall and 500 hall) During an interview with the Director of Nursing on 8-23-18 at 8:44pm she stated her expectation was the facility would maintain substantial compliance with any repeat tags. 2. F254 - Based on observation, resident interview, and staff interview the facility failed to provide linens (towels, washcloths and sheets) to 2 of 3 resident floors. During the annual recertification survey on 8-23-18, the facility was cited for F584; Based on observations, resident interviews and staff interviews the facility failed to (1) maintain walls and ceilings in resident's rooms for 13 of 16 rooms (rooms 200, 206, 218, 229, 306, 315, 403, 414, 420, 427, 429, 431 and 530)., (2) maintain a clean environment in residents rooms for 4 of 16 rooms (rooms 229, 414, 420 and 427), (3) provide nightstands without missing drawers in	F 867	" Understanding governance and leadership of the QAPI process " Analyzing and incorporating feedback, data systems, and monitoring systems to improve non-compliant practice " Creating and utilizing PIPs to enhance quality and performance " How to utilize/analyze data for systemic action Facility managers will have QAPI meetings a minimum of monthly to further include Ad-hoc meetings as needed when new areas of focus are identified (through committees, sub-committees, and other formal and informal engagements of employees, residents, and other stakeholders affiliated with the facility) to review these elements to improve systemic performance and manager engagement to identify, resolve, and monitor results based on facility findings on-going. III. Regional team members will provide oversight and recommendations of facility meetings monthly x 1 year then quarterly ongoing to assure facility adheres to identifying, developing, and implementing appropriate plans of actions to correct identified areas of focus. IV. Administrator will be responsible for overall compliance. Data results will be reviewed and analyzed at the centers monthly QAPI meeting with a subsequent POC as needed.	

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F 867	Continued From page 77	F 867		

residents rooms for 2 of 16 rooms (rooms 427 and 530) and the facility failed to (4) provide sufficient and clean linens that were not stained, thread bare or torn on 2 of 4 resident care units (units 300 and 500).

During an interview with the Director of Nursing on 8-23-18 at 8:44pm she stated her expectation was the facility would maintain substantial compliance with any repeat tags.

3. F333 - Based on record reviews and staff interviews the facility failed to administer the correct dose of anti-anxiety medication as ordered by the physician for a period of 7 months for 1 of 5 residents that were reviewed for unnecessary medications (Resident #222).

During the annual recertification survey on 8-23-18, the facility was cited for F760; Based on record review, resident interview and staff interviews the facility failed to administer 1 of 1 residents (Resident #99) thyroid medication for seven consecutive days, sedative medication for 8 consecutive days and the residents anticoagulation medication for 4 consecutive days when reviewed for significant medication errors.

During an interview with the Director of Nursing on 8-23-18 at 8:44pm she stated her expectation was the facility would maintain substantial compliance with any repeat tags.

4. F332 - Based on record review, interviews and observations the facility failed to have a medication error rate less than 5%, as evidenced by 4 medication errors out of 26 opportunities, resulting in a medication error rate of 15.38 % for 1 of 8 residents observed for medication pass

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F 867	Continued From page 78 (Resident 269). During the annual recertification survey on 8-23-18, the facility was cited for F759; Based on record review, observations, and staff interviews, the facility's medication rate was greater than 5% as evidenced by 3 medication errors out of 27 opportunities for errors (Resident #159 and Resident #180). The medication error rate was 11.11%. During an interview with the Director of Nursing on 8-23-18 at 8:44pm she stated her expectation was the facility would maintain substantial compliance with any repeat tags.	F 867		