STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345503	A. BUILDING _____ B. WING _____	11/30/2018

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LIBERTY COMMONS NSG & REH ROWA	4412 SOUTH MAIN STREET SALISBURY, NC 28147

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F 565 SS=E	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 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 record review, Resident Council	F 565	The statements made on this Plan of	12/28/18

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

Electronically Signed | 12/20/2018

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F 565	Continued From page 1 interview, and staff interview the facility failed to follow up on recurrent Resident Council concerns regarding call lights not being answered timely in 5 of 6 monthly Resident Council Meeting Minutes. Findings included: Review of the Resident Council Minutes dated 5/25/18 at 10:45 am revealed residents had continued to mention the waits for their call lights to be answered. The Activity Director was present during the meeting and recorded the minutes. Review of the Resident Council Minutes dated 6/22/18 at 10:45 am revealed residents had expressed major concerns with the nursing department including waiting long times for call lights to be answered. The Activity Director was present during the meeting and recorded the minutes. The Resident Council Minutes dated 7/20/18 at 10:45 am revealed the residents had complained that Nurses are not helping the Nurse's Aides answer call lights. The Activity Director was present during the meeting and recorded the minutes. On 8/24/18 at 10:45 am at the Resident Council Meeting Minutes voiced concerns regarding long wait times for call lights to be answered and staff entering the room, voice to resident that they will return shortly but do not return or return several hours later. The minutes reflected the Director of Nursing was present at the meeting. The Activity Director was present during the meeting and recorded the minutes.	F 565	Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the action set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 0565 Resident/Family Group and Response Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 11/26/2018 the Director of Nursing reviewed 100% of all resident council minutes for May2018 to September 2018 and identified concerns. On 11/26/2018 and 12/13/2018 the Director of Nursing completed in-service training for all Full time, part-time, and PRN nurses and nurse aides on call bell response and communication with residents. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 11/30/2018 No other residents had concerns about call bells. On 11/26/2018	

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F 565	Continued From page 2 Review of the Resident Council Meeting Minutes for 9/28/18 at 10:45 am revealed multiple council members voiced concerns regarding staff not answering call lights timely and staff turning off call light and not returning. The minutes reflected the Director of Nursing was present at the meeting. The Activity Director was present during the meeting and recorded the minutes. During an interview with the Resident Council on 11/27/18 at 10:48 am several members of the Resident Council voiced concerns that they had reported increased times for their call lights being answered on previous Resident Council Meetings without any resolution. They stated they had voice the concern in the previous Resident Council Meetings but had not had any resolution until the Resident Council Meeting on 10/26/18. Several of the members stated they had not felt like their concerns were being addressed. An interview with the Activity Director on 11/28/18 at 9:42 am revealed the residents had been complaining about the call lights not being answered quickly enough. She stated when a concern is brought up in Resident Council Meeting she will usually get the manager for the department it concerns and have them come to the meeting if the council agrees to have them visit. She stated that she had asked the Director of Nursing to attend the meeting each time the concern for call lights not being answered timely had come up. During an interview with the Director of Nursing on 11/30/18 at 9:37 am the Resident Council Meeting Minutes were reviewed. The Director of Nursing stated she did not follow up on the Resident Council Concerns for long wait times for	F 565	and 12/13/2018 the Director of Nursing completed in-service training for all Full time, part-time, and PRN nurses and nurse aides on call bell response /communication with residents. On November 30, 2018 the administrator was invited and attended Resident council meeting and there were no other concerns of slow call bell response were noted. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On December 17, 2018 the administrator in-served the Director of Nursing and Activity Director on timely response to Resident Council Concerns and creating a notebook and storage of follow up documents to assure safe keeping. After the meeting the Activity Director is to provide the Administrator the meeting minutes for review and determine the assigned person responsible for follow up. Follow up documentation is to be returned to the Administrator or designee by the next Resident council meeting. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. Beginning after December 28, 2018 (next monthly council meeting) the Administrator and or designee will begin a monthly review of Resident council	

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F 565	Continued From page 3 answering call lights and staff turning call lights off and not returning for the concerns voiced on 6/22/18, 7/20/18, 8/24/18, 9/28/18 and 10/26/18. She stated her expectation is that all staff would answer call lights timely. An interview with the Administrator on 11/30/18 at 10:55 am revealed he expected the Managers to follow up on each concern from their department and then send it to him to be signed off. He stated he believed that the issues were followed up on, but the information was just misplaced. He stated his expectation was that any resident concern would be addressed immediately.	F 565	minutes and concern /complaint response using a QA audit tool . The QA audit tool will be completed after the monthly Resident council meeting, to assure that concerns ae addressed. The findings of the audit will be reviewed in the monthly QA meeting which is attended by the Administrator, Director of Nursing, Unit manager, MDS co -coordinator, Environmental Director, Dietary manager, Heath information Manager, Social Services Director, This audit will be completed monthly x3 then randomly thereafter.	
F 584 SS=D	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. (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,	F 584		12/28/18

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F 584	Continued From page 4 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 observation and staff interview the facility failed to (1) label, cover and store bedpans, urinals, and bath basins in a sanitary manner in 3 of 4 halls and failed to (2) provide a clean bathroom free of dark yellow stain and liquid on the floor, dried stains on the edge of the toilet, and a strong smell of urine for 1 of 5 resident bathrooms observed on the 100 Hall. Findings included: 1. An observation of the 100 Hall on 11/29/18 at 8:31 am revealed an uncovered urinal on the handrail in the bathroom for rooms 104 and 110. The two urinals were not labeled to designate who they belonged to and both 104 and 110 were semiprivate rooms with two residents. An observation of the 200 Hall on 11/29/18 at	F 584	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the action set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F-0584 Safe/Clean/Comfortable/Homelike Environment	

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F 584	Continued From page 5 8:45 am revealed a bed pan on the floor in the bathroom for room 203 that was not covered or labeled. Room 203 is a semiprivate room with two residents. An observation of the 300 Hall on 11/29/18 at 9:10 am revealed uncovered and unlabeled bath pans in the bathrooms for room 301, 304, 305, 306, and 309; and an uncovered and unlabeled urinal in the bathroom for room 303. Rooms 301, 303, 304, 305, 306 and 309 were semiprivate rooms with two residents. An interview with Nurse Aide #2 on 11/29/18 at 9:30 am revealed the bed pans and bath pans were to be stored in the bathroom in clear bags and should have the resident's room numbers on them. She stated she had an in-service and was told how to store the bed pans, bath pans, and urinals but did not remember when she had the in-service. During an interview with Nurse Aide #3 on 11/29/18 at 10:05 am she stated the bed pans, bath pans, and urinals should be covered with a plastic bag and stored in the residents' bathrooms on the back of the toilet. She stated they should also be labeled with the residents' room numbers. During an interview with Nurse Aide #4 on 11/29/18 at 10:21 am she stated the bed pans and urinals should be cleaned after each use and placed in a plastic bag in the residents' bathroom on the back of the toilet; and the bath pans should be cleansed after each use, placed in a plastic bag and stored in the residents' closet. An interview with Nurse Aide #5 on 11/29/18 at 10:25 am revealed she was not aware there was	F 584	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 11/30/2018 the Director of Nursing and Environmental Services Manager cleaned , covered and labeled the urinals for resident□s for residents in rooms 104 and 110. On 11/30/2018 the Director of Nursing and Environmental Services Manager cleaned, covered and labeled the bedpans for room 203. On 11/30/2018 date the Director of Nursing removed the bath pans and urinals, obtained new equipment for residents in rooms 301, 304, 305, 306, 309, 303. On 11/30/2018 the Environmental Services Director cleaned the floor/toilet/bathroom in room 111 removing the yellow stain. On 11/30/2018 the environmental services director posted the on call schedule that lists the environmental services staff and contact telephone number for off hours and weekend environmental and housekeeping services needs. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 11/30/2018 the Environmental Services Manager completed a 100% audit of all resident bath rooms areas. The findings were that there were no other	

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F 584	Continued From page 6 a bed pan on the floor in bathroom of room 203. She stated the bed pan should be in a plastic bag on the back of the toilet. She stated she had an in-service recently and knew the bed pans and urinals should be cleaned and covered with a plastic bag in the bathroom on the back of the toilet and the bath pans should be cleaned and covered with a plastic bag in the resident's closet. 2. On 11/29/18 at 8::31 am an observation of room 111 revealed a 12 inch by 21 inch dark yellow stain on the bathroom floor in front of the toilet; dark yellow stains to the edges of the commode; and a strong odor of urine. An interview with Nurse Aide #2 on 11/29/18 at 9:56 am revealed she was not aware the bathroom for room 111 had stains on the toilet and the stained area on the floor with dark yellow liquid. She stated she had not had the assignment before and was not accustomed to the resident. She stated when there was a spill they called housekeeping to clean it up. During an interview with the house keeper on 11/29/18 at 10:26 am she stated she cleaned room 111 on 11/28/18 in the morning but had not cleaned it today. She stated it would be at least 1 ½ hours before she could clean room 111. She stated the Nurses should clean up spills after housekeeping leaves at 2:30 pm. During an interview and observation of room 111 bathroom with the House Keeping Manager on 11/29/18 at 10:40 am he stated the floor and toilet did have dried urine on them and the bathroom did need immediate attention and he would get someone to clean it immediately. The Housekeeping Manager also stated the evening	F 584	issues identified. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On Nov.30th, 2018 the Director of Nursing and Environmental Services Manager began in serving all Fulltime , Part time, and PRN nurses, aides, and housekeeping staff on : providing a a safe, clean homelike environment and ensure that personal belongings are label and care for appropriately. Housekeeping services maintain a sanitary and orderly, comfortable interior and that all residents have clean linens and clean bathrooms in which to live. If Areas are found that need additional attention, the staff is to notify housekeeping services. After 8pm the staff will contact the on call maintenance/environmental staff to address the issue. This in-service training was completed on Dec. 21st, 2018. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. Beginning on Dec.24th, 2018 the Environmental Services manager will begin a weekly audit of safe/clean/comfortable homelike environment and bathroom /equipment cleanliness, using a QA audit tool . The QA audit tool will be completed weekly x 4	

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F 584	Continued From page 7 shift laundry person is in the building until 8:00 pm and they usually clean up spills after the housekeepers leave at 2:30 pm until they leave at 8:00 pm and then the Housekeeping Manager and his assistant are on call after 8:00 pm until the next morning. During an interview with the Director of Nursing on 11/30/18 at 10:41 am she stated her expectation was the bed pans and urinals be cleaned after each use, covered with a plastic bag and stored in the residents' bathrooms on the back of the toilet. She also stated the bath pans should be cleaned, covered in a plastic bag and stored in the residents' closet. She stated that all bed pans, urinals, and bath pans should be labeled with the residents' room number and bed assignment. The Director of Nursing stated her expectation was the staff should have cleaned up the urine in the bathroom for room 111 and then called housekeeping staff to clean the toilet and mop the floor. She stated her expectation was that all staff should ensure the residents environment is clean. An interview with the Administrator on 11/30/18 at 11:07 am revealed his expectation was the residents' environment should be attended to daily and as needed and kept clean.	F 584	then monthly x3 to assure that concerns ae addressed. The findings of the audit will be reviewed in the monthly QA meeting which is attended by the Administrator, Director of Nursing, Unit manager, MDS co -coordinator, Environmental Services Manager and Dietary Manger, Heath Information Manager, Social Services Director. Date of compliance will be December 28, 2018. The Administrator is responsible for all tags in the Plan of Correction.	
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.	F 636		12/28/18

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F 636	Continued From page 8 §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive	F 636		

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F 636	Continued From page 9 assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to complete comprehensive assessments and Care Area Assessments (CAAs) not less than every 12 months and within 14 calendar days after admission for 2 of 26 residents (Resident # 29 and Resident # 186) reviewed for completion of comprehensive assessments and CAA completion. Findings included: 1.Resident # 29 was readmitted to the facility on 10/07/2016 with diagnoses that included hypertension (HTN), depression, restless leg syndrome, heart failure and muscle weakness. A comprehensive Minimum Data Set (MDS) dated 10/13/2017 was completed and transmitted to the MDS data base on 10/20/2017. The electronic medical record (EMR) for Resident # 29 revealed that quarterly MDSs were completed and transmitted to the MDS data base	F 636	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 636 COMPREHENSIVE ASSESSMENT & TIMING Corrective Action: Resident #29. Comprehensive Assessment, Assessment Reference Date (ARD) 11/24/2018. Completed, Submitted and Accepted on 12/17/2018 to the State QIES system Resident #186 Comprehensive Assessment, Assessment Reference	

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F 636	Continued From page 10 on 01/11/2018, 04/12/2018, 05/30/2018 and 08/30/2018. The EMR for Resident # 29 reviewed on 11/29/2018 revealed that a comprehensive MDS was past due and was to have been completed on 10/14/2018. The EMR had the next comprehensive MDS scheduled with an assessment reference date (ARD) of 11/24/2018. On 11/29/2018 at 9:20 AM an interview conducted with the MDS coordinator revealed that she had not realized that a comprehensive MDS dated by 10/14/2018 as indicated by a red notation in the EMR had been past due because she based the ARD of the next MDS on the ARD of the most recently completed quarterly MDS with an ARD date of 08/30/2018. An interview conducted with the MDS nurse consultant revealed that the comprehensive MDS should have been dated on or prior to 10/14/2018 and that the MDS had just been omitted in error. On 11/30/2018 at 1:35 PM an interview conducted with the facility administrator revealed that the expectation was that MDS assessments be completed as directed by the Resident Assessment Manual (RAI). 2. Resident #186 was admitted to the facility on 11/7/18. The resident's admission diagnoses included: Sepsis (the body's reaction to a severe and possibly systemic (body wide) infection), multiple pressure ulcers, low potassium, generalized weakness, cancer, history of stroke, and affective mood disorder. Review of Resident #186's Minimum Data Set (MDS) information for 11/29/18 revealed the	F 636	Date (ARD) 11/14/2018. Completed, Submitted and Accepted on 12/17/2018 to the State QIES system Identification of other residents who may be involved with this practice: All current residents with Comprehensive Minimum Data Set (MDS) assessments due have the potential to be affected by the alleged practice. On 12/14/2018 through 12/17/2018 an audit was completed by the MDS Nurse consultant to ensure that the facility had conducted a comprehensive, accurate, standardized reproducible assessment of each resident□s functional capacity. Out of the 85 current residents, 10 number of residents did not have their comprehensive assessments completed within 14 calendar days after admission, excluding readmission in which there is no significant change in the resident□s physical or mental condition and 3 number of resident did not have their Annual comprehensive assessments completed by timeframes. This assessments were completed by 12/21/2018. Systemic Changes: On 12/18/2018 The Registered Nurse (RN) Minimum Data Set (MDS) Coordinator, Licensed Practical Nurse (LPN) Support nurses any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by the	

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F 636	Continued From page 11 resident's comprehensive admission assessment and Care Area Assessments (CAAs) were not completed. An interview with the MDS Coordinator was conducted on 11/29/18 at 9:21 AM. The MDS Coordinator stated she was working on the admission assessment for Resident #186 but had not completed it yet. The MDS Coordinator stated admission assessments and the associated Care Area Assessments should be completed and locked by day 14 of the resident's stay at the facility. An interview with the MDS Consultant was conducted on 11/29/18 at 9:35 AM. The MDS Consultant stated the assessment had not been completed at the time of the interview and was late. The MDS Consultant further stated the MDS Coordinator had gotten behind and would be caught up soon. An interview was conducted with the Administrator on 11/30/18 at 1:16 PM. The Administrator stated it was his expectation for admission assessments to be completed within 14 days of admission and for the MDS Coordinator to follow the Resident Assessment Instrument (RAI) manual.	F 636	MDS nurse consultant. The education focused on: The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident□s functional capacity. OBRA-required comprehensive assessments include the completion of both the MDS and the CAA process, as well as care planning. Comprehensive assessments are completed upon admission, annually, and when a significant change in a resident□s status has occurred or a significant correction to a prior comprehensive assessment is required. They consist of: Admission Assessment, Annual Assessment, and Significant Change in Status Assessment (SCSA) and Significant Correction to Prior Comprehensive Assessment (SCPA). The Admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day 1 if: this is the resident□s first time in this facility, OR the resident has been admitted to this facility and was discharged return not anticipated, OR the resident has been admitted to this facility and was discharged return anticipated and did not return within 30 days of discharge. The Annual assessment is a comprehensive assessment for a resident that must be completed on an annual basis (at least every 366 days) unless a SCSA or a SCPA has been completed since the most recent comprehensive	

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F 636	Continued From page 12	F 636	assessment was completed. Its completion dates (MDS/CAA(s)/care plan) depend on the most recent comprehensive and past assessments□ ARDs and completion dates. This in service was completed by 12/21/2018. Any MDS nurse (full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, The Director of Nursing will review weekly, 5 residents electronic records Minimum Data Set(MDS) assessment this could be either one of the following Comprehensive assessments (Admission Assessment, Annual Assessment, and Significant Change in Status Assessment and Significant Correction to Prior Comprehensive Assessment) to ensure that the comprehensive assessments are completed timely. This will be done on weekly basis to include the weekend for 4 weeks then monthly for 3 months. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will	

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F 636	Continued From page 13	F 636	be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM(Health Information Management), Dietary Manager. The Administrator is responsible for all tags on the Plan of Correction. Date of Compliance: 12/28/2018	
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to complete quarterly assessments not less frequently than every 3 months for 2 of 26 residents (Resident #3 and Resident #4) reviewed for completion of quarterly assessments. Findings included: 1. Resident #3 was most recently admitted to the facility on 1/3/17 and was originally admitted to the facility on 8/5/16. The resident's cumulative diagnoses include: Dementia, stroke, generalized	F 638	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	12/28/18

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F 638	Continued From page 14 weakness, difficulty swallowing, anxiety, depression, and osteoporosis. Review of Resident #3's most recent Minimum Data Set (MDS) assessments revealed a quarterly assessment with an Assessment Reference Date (ARD) of 10/16/18. Review of the assessment revealed the resident was coded as having had moderately impaired cognition. The resident was coded as having required the assistance of one to two people for all activities of daily living (ADLs). Review of the previous MDS assessment revealed a quarterly assessment with an ARD of 7/14/18. Further review revealed the calculated difference between the 7/14/18 quarterly assessment ARD and the 10/16/18 quarterly assessment ARD was a time span greater than 3 months or 92 days. An interview with the MDS Coordinator was conducted on 11/29/18 at 9:21 AM. The MDS Coordinator stated she scheduled quarterly assessment 92 days or less from the previous quarterly or comprehensive assessment. The MDS Coordinator stated she was unaware the quarterly assessments for Resident #3 were more than 92 days apart from 7/14/18 and 10/16/18. An interview with the MDS Consultant was conducted on 11/29/18 at 9:35 AM. The MDS Consultant stated quarterly assessments were to be completed at 92 days or less from the previous quarterly or comprehensive assessment. The MDS consultant stated there had been another quarterly assessment opened for Resident #3, but it had not been completed and was closed as incomplete. The MDS Consultant stated the quarterly assessment with	F 638	F 638 QRTLY ASSESSMENT AT LEAST EVERY 3 MONTHS Corrective Action: Resident #4. Quarterly Assessment, Assessment Reference Date (ARD) 12/1/2018. Completed, Submitted and Accepted on 12/20/2018 to the State QIES (Quality Improvement and Evaluation System) ASAP (Assessment Submission and Processing) system Resident #3 Comprehensive Assessment, Assessment Reference Date (ARD) 10/16/2018. Completed, Submitted and Accepted on 11/21/2018 to the State QIES ASAP system. Identification of other residents who may be involved with this practice: All current residents with Quarterly Minimum Data Set (MDS) assessments due have the potential to be affected by the alleged practice. On 12/14/2018 through 12/17/2018 an audit was completed by the MDS Nurse consultant to ensure that the facility had conducted Quarterly Review assessment of each resident□s. Out of the 85 current residents, 4 number of residents did not have their quarterly review assessments completed within 92days since the ARD of the previous OBRA Quarterly Review Assessment or ARD of previous comprehensive assessment. This assessments were completed and submitted by 12/21/2018. Systemic Changes:	

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F 638	Continued From page 15 an ARD of 10/16/18 had an ARD which was 94 days after the 7/14/18 quarterly assessment. The MDS Consultant stated the 10/16/18 quarterly assessment was 2 days late, but it was completed. An interview was conducted with the Administrator on 11/30/18 at 1:16 PM. The Administrator stated it was his expectation for admission quarterly assessments to be completed no more than 92 days from the previous quarterly assessment or comprehensive assessment and for the MDS Coordinator to follow the Resident Assessment Instrument (RAI) manual. 2. Resident #4 was most recently admitted to the facility on 7/9/18 and was originally admitted to the facility on 7/23/16. The resident's cumulative diagnoses included: Dementia, psychosis, peripheral vascular disease (PVD), glaucoma, anxiety, and depression. Review of Resident #4's most recent completed Minimum Data Set (MDS) assessments revealed a comprehensive annual assessment with an Assessment Reference Date (ARD) of 7/14/18. Review of the assessment revealed the resident was coded as having had severely impaired cognition. The resident was coded as having required the assistance of one to two people for all activities of daily living (ADLs). As of the date of the review, 11/29/18 (138 days after the last quarterly assessment), review of the transmitted and accepted MDS assessments revealed no record of received assessments since 7/14/18. An interview with the MDS Coordinator was conducted on 11/29/18 at 9:21 AM. The MDS	F 638	On 12/18/2018 The Registered Nurse (RN) Minimum Data Set (MDS) Coordinator, Licensed Practical Nurse (LPN) Support nurses any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by the MDS nurse consultant. The education focused on: The facility must conduct initially and periodically a Quarterly Review Assessment of each resident□s functional capacity. OBRA-required quarterly review assessments are to be completed within 92days since the ARD of the previous OBRA Quarterly Review Assessment or ARD of previous comprehensive assessment, or significant Correction to Prior Quarterly Assessment (ARD of any of the mentioned assessments + 92 calendar days). The MDS completion date (item Z0500B must be no later than 14days after the ARD (ARD + 14 calendar days). This in service was completed by 12/21/2018. Any MDS nurse (full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring:	

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F 638	Continued From page 16 Coordinator stated she scheduled quarterly assessment 92 days or less from the previous quarterly or comprehensive assessment. An interview with the MDS Consultant was conducted on 11/29/18 at 9:35 AM. The MDS Consultant stated quarterly assessments were to be completed at 92 days or less from the previous quarterly or comprehensive assessment. The MDS consultant stated there had been an annual comprehensive assessment opened for Resident #4, but it had not been completed and was closed as incomplete. The MDS Consultant stated due to the annual having been opened and then closed, it had caused the resident's next quarterly assessment to be late. The MDS Consultant stated a quarterly assessment was scheduled but had not been completed. The MDS Consultant further stated there was a quarterly assessment scheduled but at the time of the interview it had not been completed. The MDS Consultant stated there had been a problem related to the scheduling software and there had been an annual assessment scheduled. The MDS Consultant stated when the annual assessment was cancelled, a quarterly assessment was not scheduled. The MDS Consultant stated the assessment after the 7/14/18 annual assessment should have been completed by sometime in October. The MDS Coordinator stated there was a quarterly assessment scheduled but it had not been completed and it was going to be more than 92 days from the previous assessment which was the annual assessment with an ARD of 7/14/18. The MDS Consultant stated the schedule quarterly assessment would be late. An interview was conducted with the	F 638	To ensure compliance, The Director of Nursing will review weekly, 5 residents electronic records Minimum Data Set(MDS) Quarterly assessments to ensure that the assessments are to be completed within 92days since the ARD of the previous OBRA Quarterly Review Assessment or ARD of previous comprehensive assessment, or significant Correction to Prior Quarterly Assessment (ARD of any of the mentioned assessments + 92 calendar days) and completed timely : the MDS completion date (item Z0500B must be no later than 14days after the ARD (ARD + 14 calendar days). This will be done on weekly basis to include the weekend for 4 weeks then monthly for 3 months. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager. The Administrator is responsible for all tags in the Plan of Correction. Date of Compliance: 12/28/2018	

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F 638	Continued From page 17 Administrator on 11/30/18 at 1:16 PM. The Administrator stated it was his expectation for admission quarterly assessments to be completed no more than 92 days from the previous quarterly assessment or comprehensive assessment and for the MDS Coordinator to follow the Resident Assessment Instrument (RAI) manual.	F 638		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit	F 640		12/28/18

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F 640	Continued From page 18 encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to transmit a resident assessment to the Centers for Medicare & Medicaid Services (CMS) system within 14 days after the assessment was completed for 1 of 26 (Resident #59) reviewed for transmission of Minimum Data Set (MDS) assessments. Findings included: Resident #59 was admitted to the facility on 7/9/18. Review of Resident #59's most recent Minimum Data Set (MDS) assessments revealed a quarterly assessment with an Assessment Reference Date (ARD) of 9/29/18. Further review	F 640	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 640 ENCODING/TRANSMITTING RESIDENT ASSESSMENTS Corrective Action:	

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F 640	Continued From page 19 of the 9/29/18 quarterly assessment revealed it was completed on 10/13/18. Further review revealed the assessment was accepted to the Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) System on 10/31/18 (18 days after completion). A review was completed of the Final Validation Report for the facility of the transmission of MDS information which took place on 10/31/18. Review of the report revealed quarterly assessment for Resident #59 with an ARD of 9/29/18 was transmitted on 10/31/18. Further review of the report revealed a warning for submission which stated, Record Submitted Late: The submission date is more than 14 days after the completion date on this assessment. An interview with the MDS Coordinator was conducted on 11/29/18 at 9:21 AM. The MDS Coordinator stated MDS assessments had to be submitted in 14 days or less from the time the assessment was completed. The MDS Coordinator stated she was unable to transmit the assessment because the QIES system was down. The MDS Coordinator further stated the quarterly assessment for Resident #59 was transmitted late because it was transmitted for more than 14 days after the assessment was completed. An interview with the MDS Consultant was conducted on 11/29/18 at 9:35 AM. The MDS Consultant stated the QIES system was down and the MDS Coordinator was unable to submit the MDS for Resident #59 timely. An interview was conducted with the Administrator on 11/30/18 at 1:16 PM. The	F 640	Resident #59. Significant Change in Status Assessment with Assessment Reference Date 11/27/2018 completed on 12/11/2018 and Submitted to the state QIES (Quality Improvement and Evaluation System) ASAP (Assessment Submission and Processing) system. Identification of other residents who may be involved with this practice: All current residents with Minimum Data Set (MDS) assessments due to be transmitted to the state QIES ASAP system have the potential to be affected by the alleged practice. On 12/14/2018 through 12/17/2018 an audit was completed by the MDS Nurse consultant to ensure that the facility had transmitted a resident assessment for each current resident to the Centers for Medicare and Medicaid Services (CMS) system within 14days after the assessment was completed. Out of the 85 current residents, no resident MDS assessment was found to have been submitted to the state QIES ASAP system past 14days after the MDS assessment was completed. Systemic Changes: On 12/18/2018 The Registered Nurse (RN) Minimum Data Set (MDS) Coordinator, Licensed Practical Nurse (LPN) Support nurses any other Interdisciplinary team member that participates in the MDS assessment	

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F 640	Continued From page 20 Administrator stated it was his expectation for MDS assessments to be transmitted in 14 days or less from the date of completion and for the MDS Coordinator to follow the Resident Assessment Instrument (RAI) manual.	F 640	process was in serviced /educated by the MDS nurse consultant. The education focused on: The facility must transmit a resident MDS assessment to the Centers for Medicare and Medicaid Services (CMS) system within 14days after the MDS assessment was completed. Facility must transmit all sections of the MDS 3.0 required for their State-specific instrument, including the Care Area Assessment (CAA) Summary (Section V) and all tracking or correction information. Transmission requirements apply to all MDS 3.0 records used to meet both federal and state requirements. Care plans are not required to be transmitted. Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date (V0200C2 + 14 days). All other MDS assessments must be submitted within 14 days of the MDS Completion Date (Z0500B + 14 days). For Entry and Death in Facility tracking records, information must be transmitted within 14 days of the Event Date (A1600 + 14 days for Entry records and A2000 + 14 days for Death in Facility records). This in service was completed by 12/21/2018. Any MDS nurse (full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the	

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F 640	Continued From page 21	F 640	required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, The Director of Nursing will review weekly, 5 residents electronic records Mini Data Set (MDS) assessment to include a Comprehensive assessment, Quarterly Assessment, Tracking assessment (Entry or Discharge) to ensure that the MDS assessments were transmitted to the QIES ASAP system timely. This will be done on weekly basis to include the weekend for 4 weeks then monthly for 3 months. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager. The Administrator is responsible for all tags in the Plan of Correction.	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4)	F 732		12/28/18

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	345503	A. BUILDING _____ B. WING _____	11/30/2018

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F 732	Continued From page 22 §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by:	F 732		

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F 732	Continued From page 23 Based on staff interview and review of required posted nursing staffing sheets dated 11/15/18 through 11/29/18, the facility failed to post accurate staffing information as compared to the nursing staff schedule for 15 days of the 15 days reviewed (11/15/18 through 11/29/18) and post resident census for at least two shifts of three shifts on 3 of the 15 days reviewed. Findings included: Review of the Daily Nursing Staff Schedule for 11/15/18 revealed there were 9 Nursing Assistants (NAs) on the 7:00 AM to 3:00 PM shift and 6.5 NAs on the 3:00 PM to 11:00 PM shift for entire skilled nursing facility population. Review of the daily posted Report of Nursing Staff for 11/15/18 revealed the facility had posted 8 NAs on the 7:00 PM to 3:00 PM shift and 6 NAs on the 3:00 PM to 11:00 PM shift for the entire skilled nursing facility population. Review of the Daily Nursing Staff Schedule for 11/16/18 revealed there was a Registered Nurse (RN) on the schedule as the wound nurse on the 7:00 AM to 3:00 PM shift for the entire skilled nursing facility population. Further review revealed there were 9 Nursing Assistants (NAs) on the 7:00 AM to 3:00 PM shift and 7 NAs on the 3:00 PM to 11:00 PM shift for entire skilled nursing facility population. Review of the daily posted Report of Nursing Staff for 11/16/18 revealed the facility had posted no hours for RN on staff, 7 NAs on the 7:00 PM to 3:00 PM shift, and 6 NAs on the 3:00 PM to 11:00 PM shift for the entire skilled nursing facility population.	F 732	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the action set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F-0732 Posted Nurse Staffing Information Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 11/30/2018 the Director of Nursing and staff scheduler reviewed the Daily Nurse staffing sheets, comparing it to the actual census and actual number of staff working to assure the Daily staff and census was correct on the Posted Nurse Staff information. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by the deficient practice. On 11/30/2018 the Director of Nursing assigned the 400 hall Charge Nurse staff member on 3-11 and 11-7 to review and	

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F 732	Continued From page 24 Review of the Daily Nursing Staff Schedule for 11/17/18 revealed there were 4.5 Licensed Practical Nurses (LPNs) on the schedule on the 7:00 AM to 3:00 PM shift for the entire skilled nursing facility population. Further review revealed there were 7 Nursing Assistants (NAs) on the 7:00 AM to 3:00 PM shift and 7 NAs on the 3:00 PM to 11:00 PM shift for entire skilled nursing facility population. Review of the daily posted Report of Nursing Staff for 11/17/18 revealed the facility had posted 4 LPNs on the 7:00 AM to 3:00 PM shift, 8 NAs on the 7:00 PM to 3:00 PM shift, and 6 NAs on the 3:00 PM to 11:00 PM shift for the entire skilled nursing facility population. Further review revealed there was no resident census data entered for the 7:00 AM to 3:00 PM shift, 3:00 PM to 11:00 PM shift, and 11:00 PM to 7:00 AM shift, three of three shifts. Review of the Daily Nursing Staff Schedule for 11/18/18 revealed there were 4.5 LPNs on the schedule on the 7:00 AM to 3:00 PM shift for the entire skilled nursing facility population. Further review revealed there were 7 Nursing Assistants (NAs) on the 7:00 AM to 3:00 PM shift and 7 NAs on the 3:00 PM to 11:00 PM shift for entire skilled nursing facility population. Review of the daily posted Report of Nursing Staff for 11/18/18 revealed the facility had posted 4 LPNs on the 7:00 AM to 3:00 PM shift, 8 NAs on the 7:00 PM to 3:00 PM shift, and 6 NAs on the 3:00 PM to 11:00 PM shift for the entire skilled nursing facility population. Further review revealed a resident census of 78 was entered for the 7:00 AM to 3:00 PM shift; no census was	F 732	adjust the Daily Staffing and Census sheet when changes occur for off hours , weekends , and holidays staff posting needs. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On December13,2018 date the Director of Nursing began in-servicing all Fulltime, Part time, and PRN nurses on the Required posting of staffing information and the resident census so that it is displayed in prominent location and accessible for all residents. Staff was assigned on off hours , weekends, and holidays to update as appropriate with changes to assure accuracy. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. Beginning on December 21, 2018 the Director of Nursing will begin a weekly review of the Daily Nursing Staffing sheet using a QA audit tool . The QA audit tool will be completed weekly to monitor the accuracy of the staff working and the resident census so that it is updated when changes occur in the data. The findings of the audit will be reviewed in the monthly QA meeting which is attended by the Administrator, Director of Nursing, Unit manager, MDS co -coordinator, Environmental Services Manager, Dietary	

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F 732	Continued From page 25 entered for the 3:00 PM to 11:00 PM shift or the 11:00 PM to 7:00 AM shift. Review of the Daily Nursing Staff Schedule for 11/19/18 revealed there were 7 Nursing Assistants (NAs) on the 3:00 PM to 11:00 PM shift and 3 NAs on the 11:00 PM to 7:00 AM shift for the entire skilled nursing facility population. Review of the daily posted Report of Nursing Staff for 11/19/18 revealed the facility had posted 6 NAs on the 3:00 PM to 11:00 PM shift and 4 NAs on the 11:00 PM to 7:00 PM shift for the entire skilled nursing facility population. Review of the Daily Nursing Staff Schedule for 11/20/18 revealed there were 7 Nursing Assistants (NAs) on the 7:00 AM to 3:00 PM shift and 5 NAs on the 3:00 PM to 11:00 PM shift for the entire skilled nursing facility population. Review of the daily posted Report of Nursing Staff for 11/20/18 revealed the facility had posted 8 NAs on the 7:00 PM to 3:00 PM shift and 6 NAs on the 3:00 PM to 11:00 PM shift for the entire skilled nursing facility population. Review of the Daily Nursing Staff Schedule for 11/21/18 revealed there were 5 LPNs on the schedule on the 7:00 AM to 3:00 PM shift for the entire skilled nursing facility population. Further review revealed there were 8 Nursing Assistants (NAs) on the 7:00 AM to 3:00 PM shift and 6.5 NAs on the 3:00 PM to 11:00 PM shift for the entire skilled nursing facility population. Review of the daily posted Report of Nursing Staff for 11/21/18 revealed the facility had posted 4 LPNs on the 7:00 AM to 3:00 PM shift, 9 NAs on	F 732	manager, Heath information Manager, Social Services The administrator is responsible for the plan of correction.	

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the 7:00 PM to 3:00 PM shift, and 6 NAs on the 3:00 PM to 11:00 PM shift for the entire skilled nursing facility population.

Review of the Daily Nursing Staff Schedule for 11/22/18 revealed there were 9 Nursing Assistants (NAs) on the 7:00 AM to 3:00 PM shift and 7 NAs on the 3:00 PM to 11:00 PM shift for the entire skilled nursing facility population.

Review of the daily posted Report of Nursing Staff for 11/22/18 revealed the facility had posted 8 NAs on the 7:00 PM to 3:00 PM shift and 6 NAs on the 3:00 PM to 11:00 PM shift for the entire skilled nursing facility population.

Review of the Daily Nursing Staff Schedule for 11/23/18 revealed there were 8 Nursing Assistants (NAs) on the 7:00 AM to 3:00 PM shift and 5.5 NAs on the 3:00 PM to 11:00 PM shift for the entire skilled nursing facility population.

Review of the daily posted Report of Nursing Staff for 11/23/18 revealed the facility had posted 7 NAs on the 7:00 PM to 3:00 PM shift and 6 NAs on the 3:00 PM to 11:00 PM shift for the entire skilled nursing facility population.

Review of the Daily Nursing Staff Schedule for 11/24/18 revealed there were 8 Nursing Assistants (NAs) on the 7:00 AM to 3:00 PM shift and 5 NAs on the 3:00 PM to 11:00 PM shift for the entire skilled nursing facility population.

Review of the daily posted Report of Nursing Staff for 11/24/18 revealed the facility had posted 7 NAs on the 7:00 PM to 3:00 PM shift and 6 NAs on the 3:00 PM to 11:00 PM shift for the entire skilled nursing facility population.

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Review of the Daily Nursing Staff Schedule for 11/25/18 revealed there was 1 RN on the schedule on the 7:00 AM to 3:00 PM shift for the entire skilled nursing facility population. Further review revealed there were 4.5 NAs on the 3:00 PM to 11:00 PM shift for the entire skilled nursing facility population.

Review of the daily posted Report of Nursing Staff for 11/25/18 revealed the facility had posted 0 RNs on the 7:00 AM to 3:00 PM shift and 6 NAs on the 3:00 PM to 11:00 PM shift for the entire skilled nursing facility population. Further review revealed there was no resident census data entered for the 7:00 AM to 3:00 PM shift, 3:00 PM to 11:00 PM shift, and 11:00 PM to 7:00 AM shift, three of three shifts.

Review of the Daily Nursing Staff Schedule for 11/26/18 revealed there were 9 Nursing Assistants (NAs) on the 7:00 AM to 3:00 PM shift and 7 NAs on the 3:00 PM to 11:00 PM shift for the entire skilled nursing facility population.

Review of the daily posted Report of Nursing Staff for 11/26/18 revealed the facility had posted 8 NAs on the 7:00 PM to 3:00 PM shift and 6 NAs on the 3:00 PM to 11:00 PM shift for the entire skilled nursing facility population.

Review of the Daily Nursing Staff Schedule for 11/27/18 revealed there were 8 Nursing Assistants (NAs) on the 7:00 AM to 3:00 PM shift and 6.5 NAs on the 3:00 PM to 11:00 PM shift for the entire skilled nursing facility population.

Review of the daily posted Report of Nursing Staff for 11/27/18 revealed the facility had posted 7

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NAs on the 7:00 PM to 3:00 PM shift and 6 NAs on the 3:00 PM to 11:00 PM shift for the entire skilled nursing facility population.

Review of the Daily Nursing Staff Schedule for 11/28/18 revealed there were 10 Nursing Assistants (NAs) on the 7:00 AM to 3:00 PM shift for the entire skilled nursing facility population.

Review of the daily posted Report of Nursing Staff for 11/28/18 revealed the facility had posted 9 NAs on the 7:00 PM to 3:00 PM shift the entire skilled nursing facility population.

Review of the Daily Nursing Staff Schedule for 11/29/18 revealed there were 9 Nursing Assistants (NAs) on the 7:00 AM to 3:00 PM shift, 5 NAs on the 3:00 PM to 11:00 PM shift, and 3 NAs for the 11:00 PM to 7:00 AM shift for the entire skilled nursing facility population.

Review of the daily posted Report of Nursing Staff for 11/29/18 revealed the facility had posted 7 NAs on the 7:00 PM to 3:00 PM shift, 6 NAs on the 3:00 PM to 11:00 PM shift, and 4 on the 11:00 PM to 7:00 AM shift for the entire skilled nursing facility population.

Further review of all 15 daily posted Report of Nursing Staff sheets, 11/15/18 through 11/29/18, revealed no hand-written adjustments to the printed staffing for RNs, LPNs, and CNAs. In addition, review of the recorded census revealed no changes to the posted census from shift to shift which would reflect admissions and discharges.

An interview was conducted with the Staffing Scheduler on 11/29/18 at 4:36 PM. The

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scheduler stated she filled out the daily posted Report of Nursing Staff Monday through Friday when she was at the facility with the information she got from the Daily Nursing Staff schedule prior to any changes made and on the weekend the RN was responsible for posting and updating the staffing sheet. The Scheduler stated she did not change the staffing on the Report of Nursing Staff and the support nurse or one of the nurses was to update the staffing on the sheet related to call outs or other adjustments in staffing. The Scheduler stated the census number was not changed for 2nd or 3rd shift to reflect the actual census at the time of the shift. The scheduler stated she put the census on the Report of Nursing Staff during the 7:00 AM to 3:00 PM shift and put the same number down for the 3:00 PM to 11:00 PM and the 11:00 PM to 7:00 AM shift. The Scheduler reviewed the Report of Nursing Staff and compared it to the Daily Nursing Staff Schedule and discovered discrepancies for the following days: 11/16/18, 11/17/18, 11/18/18, 11/19/18, 11/20/18, 11/21/18, 11/24/18, and 11/25/18.

An interview was conducted with the Director of Nursing (DON) on 11/30/18 at 1:34 PM. The DON stated it was her expectation for the daily posted Report of Nursing Staff sheet to be accurate and complete.

An interview was conducted with the Administrator on 11/30/18 at 1:16 PM. The Administrator stated it was his expectation for the daily posted Report of Nursing Staff sheet to be accurate and complete.